

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13296

Item 2 Film G381 10/18/66 mh

CERTIFICATE OF DEATH

13290

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pa. Maryland</b> b. COUNTY <b>Franklin Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>3 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jackson Conv. Home</b>		d. STREET ADDRESS <b>37 N. Main St. Jackson Conv. Home</b>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>F.</b> Last <b>Agnew</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Merchn.</b>	9. AGE (In years last birthday) <b>87</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Mercersburg, Pa., R.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Agnew</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Eliza Rhea</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>179-07-3451A</b>	
17. INFORMANT <b>James E. Agnew</b>		Address <b>Littleton, Colo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emphysema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>5271</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1963</b> , to <b>Sept. 1966</b> that (I) (we) last saw the deceased alive on <b>Sept. 16 1966</b> , and that death occurred at <b>10 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks</b>		22b. DATE SIGNED <b>9/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>580 Northern Avenue Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/30/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Mercersburg, Pa.</b>
24. FUNERAL DIRECTOR <b>J. M. Geringer</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1966</b>	
ADDRESS <b>Mercersburg, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

13300

OFFICE OF THE

13300

*James M. Smith*

CERTIFICATE OF DEATH

13297

13291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>14 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>554 West Church St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>554 West Church St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>LEE</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1870</u>
9. AGE (In years last birthday) <u>96</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Wash Con Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Stouffer</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Mace</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Gladys Gower</u>		Address <u>554 W. Church St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> , 19 <u>66</u> , to <u>Sept 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 26</u> , 19 <u>66</u> , and that death occurred at <u>4:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. M. Mandell</u>		22b. DATE SIGNED <u>9/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANDREW M. MANDELL, M.D.</u>		22d. ADDRESS <u>119 E. ANTIETAM ST., HAGERSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash C. Md.</u>
24. FUNERAL DIRECTOR <u>Hagerstown Md</u> ADDRESS <u>Andrew K. Coffman Funeral Home Inc</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Fredrick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Agreston</u>	c. LENGTH OF STAY IN lb. <u>8 hrs 15 m.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Myersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>10-2</u>	
3. NAME OF DECEASED (Type or print) <u>BETTY SANE BAKER</u>		4. DATE OF DEATH <u>September 26 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash Co, Md</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONRAD E. BAKER</u>		14. MOTHER'S MAIDEN NAME <u>MARY SANE HARR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CONRAD E. BAKER</u>		Address <u>Myersville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5 PM 9-25, 1966</u> , to <u>12:30 AM, 1966</u> , that (we) last saw the deceased alive on <u>9-25 1966</u> , and that death occurred at <u>1:30 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Charles F. Hess</u>		22b. DATE SIGNED <u>9-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>		22d. ADDRESS <u>Smithsburg, Maryland 21783</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 27, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u>	23d. LOCATION (City or Town) (County) (State) <u>Myersville Fred. Md</u>
24. FUNERAL DIRECTOR <u>Paul J. Barte</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
ADDRESS <u>Myersville Md</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>	

6-232444

13528

CERTIFICATE OF DEATH

13528

Name of Deceased		Date of Birth		Sex	
Age		Date of Death		Place of Death	
Cause of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Certificate		Date of Registration		Date of Filing	

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
BUREAU OF VITAL STATISTICS  
WASHINGTON, D.C. 20461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
13293 CERTIFICATE OF DEATH 13293															
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>30 YR S.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>39 E. WASHINGTON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>MARY</b>			First <b>MARY</b>			Middle <b>ADA</b>			Last <b>BAUMGARDNER</b>			4. DATE OF DEATH <b>SEPTEMBER 24 19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/6/1886</b>		9. AGE (in years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SCHOOL TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>DAVID L. WOLFINGER</b>						14. MOTHER'S MAIDEN NAME <b>MARTHA A. STINE</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. VIRGINIA MYERS</b>		Address <b>RT. 3 GREENCASTLE PENNA.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis - cachexia</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>yrs</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>- - -</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 1961, to <b>Sept. 24</b> , 1966, that (I) (we) last saw the deceased alive on <b>Sept. 24</b> 19 66, and that death occurred at <b>P. M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Harold R. Tritch, Jr.</b>										22b. DATE SIGNED <b>9-26-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harold R. Tritch, Jr M.D.</b>						22d. ADDRESS <b>302 N. Potomac Street Hagerstown, Md</b>									
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE THEREOF <b>9/27/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>						
24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR <b>SEP 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

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13322

WASHINGTON

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30 YR. 8.

WASHINGTON

39 E. WASHINGTON ST.

WASHINGTON COUNTY HOSPITAL

22 SEPTEMBER 1944

MANHATTAN

ADA

MANHATTAN

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WHITE

SCHOOL

MANHATTAN

RETIRED SCHOOL TEACHER

MANHATTAN A. STINE

DAVID L. WOLFFINGER

PT. 3 GREENWICH

MANHATTAN

MANHATTAN

NO

Cardinal (St. Louis) - co-eclectic  
intermediate to advanced



11 Sept. 44

Sept. 44

Mr. David L. Wolffinger, 302 N. Pennsylvania Avenue, Washington, D.C.

WASHINGTON

BOSS HILL CEM.

DECEASED 2/27/66

With many thanks for the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13300						13294					
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>MARYLAND</b> COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN lb <b>1 MON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Clear Spring</b>				d. STREET ADDRESS <b>Cumberland St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Md. State Hosp</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ann Elizabeth Boyd</b>			First Middle Last			4. DATE OF DEATH <b>Sept 25 1966</b>			Month Day Year		
5. SEX <b>F</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-28-79</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home duties</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>DANIEL G. BOYD</b>				14. MOTHER'S MAIDEN NAME <b>LUCY V. BOYD</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>			
16. SOCIAL SECURITY NO. <b>216-46-488</b>				17. INFORMANT <b>George Boyd</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive failure</b> DUE TO (b) <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerosis, generalized</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-22-66</b> to <b>9-25-66</b> , that (I) (we) last saw the deceased alive on <b>9-25-66</b> , and that death occurred at <b>10P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin G. Riley</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>9-26-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edwin G. Riley</b>						22d. ADDRESS <b>W. Md. State Hosp, Hagerstown Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>9/28/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b>						ADDRESS <b>Clear Spring, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 5 1966</b>		
						25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>					



13300

WASHINGTON

HAGERS TOWN

Western Md. State Hosp

Ann

F Wm

HOUSEKEEPER

DANIEL G

BOYD

216-41-450

No home

Acute congestive failure  
Coronary sclerosis  
Arteriosclerosis generalized

10 yrs  
10 yrs

8-22-66

✓ 9-26-66

Edwin G. Riley  
Channing B. Riley

W. Md State Hosp, Hagerstown

13300

13300

Rock Hill Cemetery

Hagerstown

Clear Spring

100

13300

13300

MARYLAND

WASHINGTON

1 Mon. 1961 - Clear Spring

State Hosp

Elizabeth

Boyd

11-28-79

MARYLAND

LUCY V BOYD

Home dates

USA

216-41-450

Cardiac

Acute congestive failure

10 yrs

Arteriosclerosis generalized

✓



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
13301

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13295

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>SHENANDOAH</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>8 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home wood Church Home</u>		d. STREET ADDRESS <u>CHURCH STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rush</u> Last <u>Boyer</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodstock, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles F. Rush</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Alice Hattel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-54-7381</u>	
17. INFORMANT <u>Mark G. Wagner</u>		Address <u>2750 Va Ave Williamsport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> DUE TO <u>C</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Jan 29</u> 19 <u>66</u> to <u>Sept 28</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>66</u> and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert P. Cooney</u> M.D.		22b. DATE SIGNED <u>9-29-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert H. Cooney</u>		22d. ADDRESS <u>137 W. Wash Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>9/28/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MASSA NUTTEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Woodstock VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES M. ROUZER</u>		ADDRESS <u>HAGERSTOWN, MARYLAND</u>	
25a. REC'D BY REGISTRAR <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1930

CERTIFICATE OF DEATH

1930

CHURCH STREET

CHURCH STREET

CHURCH STREET

CHURCH STREET

CHURCH STREET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13296

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Frederick</b> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>10-2</b>	
3. NAME OF DECEASED (Type or print) <b>Lloyd R. Brandenburg</b>		4. DATE OF DEATH <b>September 2, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1895</b>
9. AGE (In years birth day) <b>71</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Co. Roads</b>	
11. BIRTHPLACE (State or foreign country) <b>Wolfsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry L. Brandenburg</b>		14. MOTHER'S MAIDEN NAME <b>Louise Grossnickle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-01-3992</b>	
17. INFORMANT <b>Mrs Elizabeth Brandenburg</b>		Address <b>Myersville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lymphatic leukemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2040</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-31-1959</b> , to <b>9-2-1966</b> , that I last saw the deceased alive on <b>9-1-1966</b> , and that death occurred at <b>1:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles F. Hess</b> M.D. <b>9-2-66</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D. <b>9-2-66</b>			
PHYSICIAN'S NAME (Type) <b>Charles F. Hess</b> <b>Smithburg, Maryland</b>			
22a. BURIAL, CREMATION, REMAINS <b>Burial</b>		22b. DATE THEREOF <b>Sept. 4, 1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>		22d. LOCATION (City, town, or county) (State) <b>Myersville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>		ADDRESS <b>Myersville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 6 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



CERTIFICATE OF DEATH

13303

13297

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> c. LENGTH OF STAY IN 1b <b>16 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> d. STREET ADDRESS <b>Box 173</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William John Brittain</b>		4. DATE OF DEATH Month Day Year <b>September 13, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1905</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taylor &amp; Musician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tresco Hazelton. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Brittain</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Gallop</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>207-10-2392</b>	
17. INFORMANT <b>Carrie M. Nelson, Box 173, Funkstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease &amp; Coronary Occlusion</b> DUE TO (b) <b>Extension of Heart Disease</b> DUE TO (c) <b>Bronchial Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>3 1/2</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31</b> , 19 <b>66</b> , to <b>Sept 13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 10</b> , 19 <b>66</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE SIGNED <b>9/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933

CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>45 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1020 Lincoln St.</u>				d. STREET ADDRESS <u>1020 Lincoln St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Faye</u> Middle <u>Elizabeth</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5, 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Gapland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Lee Gordon</u>				14. MOTHER'S MAIDEN NAME <u>Laura Lavaia Boyer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6402D</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mr. Daniel H. Brown 1016 Lincoln St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		M.D. <u>Howard N. Weeks, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		9/13/66 22. DATE SIGNED	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		580 Northern Ave. Address (Street, city, town, or county) <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Host</u> <u>Rest Haven Funeral Chapel</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 16 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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RECEIVED EXHIBIT OF DEATH

FOR THE  
DEATH OF

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western/State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>2800 - Shepherd St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Timothy Carroll</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/1892</b>
9. AGE (In years last birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William O. Carroll</b>		14. MOTHER'S MAIDEN NAME <b>? Sweeney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Annette M. Powell (above add-ress)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>144X Carcinoma of mouth with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-30</b> , 19 <b>66</b> , to <b>9-30</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-30</b> , 19 <b>66</b> , and that death occurred at <b>8:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Edmund J. Riley</b>		22b. DATE SIGNED <b>9-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund J. Riley</b>		22d. ADDRESS <b>Western/State Hosp. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Mt. Rainier, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15302

INSTRUMENT OF DEATH

15302

Respect Timothy Carroll  
Sept 30, 1966

Respect Timothy Carroll  
Sept 30, 1966

Timothy Carroll

Sept 30, 1966  
A-30-66  
A-30-66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13306									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Gateway Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>No. Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Burchell</b> Last <b>Castleman</b>					4. DATE OF DEATH Month <b>September</b> Day <b>27</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1898</b>		9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Brucetown, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Samuel Castleman</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Aulabaugh</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>232-01-8646</b>		17. INFORMANT <b>Donald R. Castleman-Martinsburg, West Va.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO <b>Arteriosclerotic Heart Disease</b> (b) <b>Arteriosclerosis, Generalized</b> (c) <b>Hypertensive C.V. Disease - Pulmonary Embolism</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive C.V. Disease - Pulmonary Embolism</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>Years</b> <b>Years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>22 Sept</b> , 19 <b>66</b> , to <b>27 Sept</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>27 Sept</b> 19 <b>66</b> , and that death occurred at <b>1:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>								22b. DATE SIGNED <b>29 Sept 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. N. Fendler</b>								22d. ADDRESS <b>218 N. Potomac St. Hagerstown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-30-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Norborne Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Martinsburg, Berkeley, W. Va.</b>		
24. FUNERAL DIRECTOR <b>[Signature]</b> <b>Brown Funeral Home</b> <b>Martinsburg, W. Va.</b>						25a. REC'D BY REGISTRAR <b>[Signature]</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



13506

13506

Washington

Hepburn

1000 15th Street

1000 15th Street

John

Harmon

Harmon

1000 15th Street

1000 15th Street

Male

White

X

March 7, 1945

22

Washington

Washington, Virginia

John Samuel Harrison

Virginia Harrison

1000-01-8045

1000-01-8045

1000-01-8045

1000-01-8045

1000-01-8045

1000-01-8045

1000-01-8045

1000-01-8045



## CERTIFICATE OF DEATH

13301

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>31 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>643 Washington Ave</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>643 Washington Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT JAMES CAUSER</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 11 1904</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crew Dispatcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James F. Causer</b>		14. MOTHER'S MAIDEN NAME <b>Wilhemina Beattie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-6532</b>	
17. INFORMANT <b>Mrs Ethel A. Causer</b>		Address <b>643 Washington Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Pulmonary infarction (embolism)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>154X</b> DUE TO <b>2. Carcinoma of the rectum with metastasis to the liver</b> (c) <b>2 1/2 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>March 29, 1966</b> , to <b>Sept. 13, 1966</b> , that (4) (we) last saw the deceased alive on <b>9/13</b> 19 <b>66</b> , and that death occurred at <b>11:45 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>Sept. 14, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>
24. FUNERAL DIRECTOR <b>Hagerstown Md.</b> <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b> 25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13301

REMARKS OF DEATH

13301



Name of deceased		Age		Sex		Race		Religion		Marital status		Occupation		Cause of death		Date of death		Place of death		Signature of physician		Signature of witness	

## CERTIFICATE OF DEATH

13308

13302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN lb <b>4 mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND STATE HOSPITAL</b>		e. STREET ADDRESS <b>3944 SUITLAND ROAD</b>	
3. NAME OF DECEASED (Type or print) First <i>Catherine</i> Middle <i>Lucy</i> Last <i>Costello</i>		4. DATE OF DEATH Month <i>9</i> Day <i>9</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-96</i>
9. AGE (In years, months, and days) <i>70 yrs.</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM E. SHEAHAN</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA MEADE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>578-09-9768-B</b>		17. INFORMANT <b>HARRY J. COSTELLO (HUSBAND)</b>	
18. ADDRESS <b>5911 RYLAND DR. BETHESDA, MD.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>lobular pneumonia</i> (b) <i>myocardial infarction</i> DUE TO <i>atherosclerosis</i> (c) <i>"</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>unknown</i> <i>"</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>① Old cerebral thrombosis ② atherosclerosis, general</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-28, 1966</i> to <i>9/9, 1966</i> that (I) <del>(we)</del> last saw the deceased alive on <i>9/9, 1966</i> and that death occurred at <i>8:13 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Victor L. Ramos</i> M.D.		22b. DATE SIGNED <i>Sept. 9, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Victor Ramos</i>		22d. ADDRESS <i>1500 Penna. Ave., Hagerstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-12-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <i>F. J. Collins</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>WASHINGTON, D. C.</b>	
25d. DATE <b>SEP 14 1966</b>		25e. ADDRESS <b>3821 14TH. ST. N.W.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13805

13805

TO

lobular pneumonia  
microcystic cystitis  
glomerulonephritis

① Old cerebral hemorrhage ② glomerulonephritis

1-1-1

13309

CERTIFICATE OF DEATH

13303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN lb <u>32 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>164 West Washington St</u>				d. STREET ADDRESS <u>164 West Washington St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK WARREN COVER</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 1872</u>		9. AGE (In years last birthday) <u>94</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Thurmont Fred Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Henry Cover</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>05-10-6866</u>		17. INFORMANT Address <u>Miss Dorothy Cover 164 W. Wash St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1966</u> , to <u>death</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>July 16, 1966</u> , and that death occurred at <u>1:00 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>John C. Stauffer</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>				22d. ADDRESS <u>145 S. Prospect St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman Funeral Home Inc</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



6084


20853



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and for any event within 72 hours after death.

<div> <div>Items 20&amp;21 Film 381</div> <div>13310</div> <div>13304</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>75-3</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ft. Loudon, Pa.</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Howard</b> Middle <b>N.</b> Last <b>Coy</b>			<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>23</b> Year <b>1966</b>						
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5/6/16</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Coal &amp; stone</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Saxton, Pa.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Jesse Coy</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Alda Dick</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>			<b>16. SOCIAL SECURITY NO.</b> <b>193-09-6713</b>		<b>17. INFORMANT</b> Address <b>Masood F.H., Saxton, Pa.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of spleen</b> <b>936.6</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>fracture of ninth left rib</b> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>13 days</b> <b>same</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Etiology of above being investigated.</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Pending investigation</b>						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>9</b> p.m. <b>Sept 9 1966</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>American Legion Ft. Loudon Pa.</b>		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> 			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>580 Northern Ave. Hagerstown, Md.</b> <b>Address (Street, city, town, or county)</b>						
<b>EXAMINER'S NAME (Type)</b> <b>Howard N. Weeks, M.D.</b>			<b>22. DATE SIGNED</b> <b>9/23/66</b>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>9/25/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fockler Cem.</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Saxton, Penna.</b>		
<b>24. FUNERAL DIRECTOR</b> 			<b>ADDRESS</b> <b>Mercersburg, Pa.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>SEP 27 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 		

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## CERTIFICATE OF DEATH

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13305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>900 Penna Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>MARKWOOD</u> Last <u>COYLE</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 1903</u> 63 yrs.		9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 Year Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Keedysville Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sylvester Coyle</u>				14. MOTHER'S MAIDEN NAME <u>Florence Rohrer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>232-26-5464</u>		17. INFORMANT <u>Mrs Mildred E. Coyle</u> Address <u>900 Penna Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Repeated hemorrhage</u> 5410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bleeding</u> (c) <u>Duodenal ulcer</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary emphysema</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 27, 1966</u> , to <u>Sept. 27, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 27 1966</u> , and that death occurred at <u>8:00PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>Sept. 27, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M. D.</u>	
22d. ADDRESS <u>100 Professional Arts Bldg, Hagerstown Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman</u> funeral Home Inc				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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NORTHEAST OF OCEAN

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*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>50 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>761 Spruce St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Marie</u> Last <u>Cressler</u>		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899</u> 9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Keedysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Kindle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Churchey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-156</u>	
17. INFORMANT <u>Mrs. Dolly Wissinger</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Long coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic heart disease</u> (c) <u>Unrecognized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>unknown</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>G-70</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-30</u> , 19 <u>66</u> , to <u>Sept 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 19</u> , 19 <u>66</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. R. Landis</u>		22b. DATE SIGNED <u>9-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. R. Landis</u>		22d. ADDRESS <u>310 N. DORA AVE HAGERSTOWN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Host</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Hagerstown, Md.</u>	

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Wm. C. Brown



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13312

13307

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>21 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> 16-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>9312 Fontana Drive</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Washington</u> Last <u>Cupp</u>		4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 22, 1879</u>
		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Jacksonville, Alabama</u>
		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Cupp</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>246-09-5823</u>	
		17. INFORMANT <u>Charles J. Cupp</u> Address <u>North Carolina</u>	
		<u>609 Charles Ave. Charlotte,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Pulmonary emphysema</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin G Riley</u>		22b. DATE SIGNED <u>9-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin G Riley</u>		22d. ADDRESS <u>1500 Penna Ave, Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal &amp; Burial</u>	23b. DATE THEREOF <u>9/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Charlotte Mecklenburg, N.C.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1966</u>	
<u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**WILEY**

12305

Generalized extensorismus

Wm. D. Abbott  
Edwin G. Riley  
Glenn H. Riley  
1000 Penn. Ave. Washington  
- P-7-6

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN lb <u>56 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>228 S. Locust St.</u>		d. STREET ADDRESS <u>228 S. Locust St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Clayton</u> Last <u>Deaver</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>	11. BIRTHPLACE (State or foreign country) <u>Rileyville, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Deaver</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Walker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>217-10-2803</u>		17. INFORMANT <u>Mrs. Ollie Deaver</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized and</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic Hypertrophy, Benign</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>9-30-66</u>		23. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hoot</u> Address <u>Rest Haven Funeral Chapel, Hagerstown, Md.</u>		25. REC'D BY REGISTRAR DATE <u>OCT 4 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u>	

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W. C. Carter

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>2 Days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville Rfd. 2</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>						d. STREET ADDRESS <b>Brownsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Catherine Deener</b>				4. DATE OF DEATH Month Day Year <b>September 12, 19 66</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1869</b>		9. AGE (In years last birthday) <b>96 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>10 11</b>	IF UNDER 24 HRS. <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Burkettsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Mason Coulter</b>				14. MOTHER'S MAIDEN NAME <b>Julia Gordon</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. John Jennings, Brownsville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STRANGULATED HERNIA</b> 5615 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CORONARY INSUFFICIENCY</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>9-10-66</b> , 19__, to <b>9-12-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>9-12-66</b> , 19__, and that death occurred at <b>1-30 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <i>J.R. Dwyer</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-13-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. R. DWYER, M.D.</b>				22d. ADDRESS <b>119 KING ST., HAGERSTOWN, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-14-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brownsville, Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 15 1966</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 High St.</u>				d. STREET ADDRESS <u>24 High St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Belva</u> Middle <u>Gay</u> Last <u>Derr</u>				4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1897</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Venton Luther Palmer</u>				14. MOTHER'S MAIDEN NAME <u>Martha Jane Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-6311</u>		17. INFORMANT <u>Mr. C.O. Derr</u> Address <u>24 High St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>Sept. 4</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 26</u> , 19 <u>66</u> , and that death occurred at <u>6 P.</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>A. E. W. Ditto, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horok</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Silver Spring MD</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <i>120 Greenhill Drive</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hagerstown MD</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>DENNIS</i>	First <i>L</i> Middle <i>DHERIT</i> Last	4. DATE OF DEATH <i>Sept 4</i>	Day <i>4</i> Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 5 1946</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public School</i>	11. BIRTHPLACE (State or foreign country) <i>Pa</i>
13. FATHER'S NAME <i>W. H. Dherit</i>		14. MOTHER'S MARIEN NAME <i>Lillian M. Krueger</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>174-36-6454</i>	
17. INFORMANT <i>Mrs Paul Sheffer</i>		Address <i>120 Greenhill Drive Hagerstown MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>8164</i> DUE TO <i>FRACTURED SKULL</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>INTRABDOMINAL HEMORRHAGE</i> DUE TO <i>FRACTURED LEFT FEMUR</i> (c) <i>SEVERE LACERATIONS OF LEG &amp; FACE</i>			INTERVAL BETWEEN ONSET AND DEATH <i>INSTANT</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>IN COLLISION WITH ONCOMING CAR</i>	
20c. TIME OF INJURY Month, Day, Year <i>12:45 a.m. 9-4 66</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>STATE RT 65</i>	20f. (City or town) (County) (State) <i>FAIRPLAY, WASH. MD.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr E.W. Ditto</i>		22. DATE SIGNED <i>9-4-66</i>	
EXAMINER'S NAME (Type) <i>DR. E.W.DITTO</i>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept 7 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FISSELS</i>	23d. LOCATION (City, town or county) (State) <i>Glen Rock Pa Pa</i>
24. FUNERAL DIRECTOR <i>H.C. Geiple</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>GLEN ROCK, PA</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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DR. E.W. DITTO, JR.

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN lb <u>9 Weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport sanatorium</u>		d. STREET ADDRESS <u>609 Frederick St</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>MARGARET</u> Last <u>DICK</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 26 1876</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Doarnberger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Purcell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Charlotte Bellomy</u>		Address <u>610 Frederick St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4331 DUE TO (b) <u>Atherosclerotic cardio-vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Disease</u> Dysrhythmia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular Fibrillation</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 Weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, Factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>9-17</u> , 19 <u>66</u> to <u>9-17</u> , 19 <u>66</u> that (2) we last saw the deceased alive on <u>9-17</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>9-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

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STATE OF TEXAS

1831

(M)

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "Warrant" and "County" are faintly visible.]*

*[Vertical text on the right margin, likely a filing or archival stamp, mostly illegible.]*



13319

CERTIFICATE OF DEATH

13313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>1 Week</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1101 Maugans Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LESTER BREWER DRAPER</b> First Middle Last 4. DATE OF DEATH <b>Sept 14 1966</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>June 27 1885</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Williamsport Wash Co Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel S. Draper</b>		14. MOTHER'S MAIDEN NAME <b>Florence Wolford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-9384</b>	
17. INFORMANT <b>Miss Anna M. Draper</b>		Address <b>1101 Maugans Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Arteriosclerosis, generalized</b> DUE TO (c) <b>Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Prostatic Hypertrophy, Benign</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 8, 1966</b> , to <b>Sept 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 13, 1966</b> , and that death occurred at <b>2:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>9-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		22d. ADDRESS <b>217 West Washington Street Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/16/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

HSEI

21587

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13320

## CERTIFICATE OF DEATH

13314

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>13 1/2 hrs 51 yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>74 Madison Ave., Hagerstown</b>		d. STREET ADDRESS <b>74 Madison Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Michael NMN Farrie</b>		4. DATE OF DEATH Month <b>September</b>		Day <b>16</b>		Year <b>1966</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1904</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b>		11. IF UNDER 24 HRS. Days <b>19</b>		12. IF UNDER 24 HRS. Hours <b>19</b>		13. IF UNDER 24 HRS. Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania (McKeesport)</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Joseph Farrie</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cario Valentine</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-4732</b>		17. INFORMANT <b>Mrs. Michael Farrie</b>		Address <b>74 Madison Ave.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, gallbladder with extensive liver met.</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1551</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 13, 1966</b> , to <b>Sept. 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 15, 1966</b> , and that death occurred at <b>7:45 AM</b> , from causes and on the date stated above.		22a. SIGNATURE <b>J. H. Kehne, M. D.</b>		22b. DATE SIGNED <b>9-16-66</b>		22c. PHYSICIAN'S NAME (Type) <b>J. H. Kehne, M. D.</b>		22d. ADDRESS <b>1229 Ravenwood Hts., Hagerstown, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash. Md.</b>		24. FUNERAL DIRECTOR <b>Wm. C. Hunt</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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1331

1331

STATE OF TEXAS

County of ... State of Texas

Know all men by these presents, that ...

for and to the use of ...

do hereby certify that ...

Witness my hand and seal of office this ... day of ...

1907-11-17

Notary Public in and for the State of Texas

My commission expires this ... day of ...

Notary Public in and for the State of Texas

My commission expires this ... day of ...

*J. A. Johnson*

*Wm. C. ...*

Notary Public in and for the State of Texas  
My commission expires this ... day of ...

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13321					13315				
CERTIFICATE OF DEATH					13315				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b <b>18 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>126 Fairground Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANN MATILDA FAULKNER</b>					4. DATE OF DEATH Month Day Year <b>Sept. 26 19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 13, 1886</b>		9. AGE (In years last birthday) <b>80 yrs.</b> IF UNDER 1 YEAR: Months <b>2</b> Days <b>13</b> Hours <b>13</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Hosiery Mill</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES FAUGHANDER</b>					14. MOTHER'S MAIDEN NAME <b>ANN GROSCH</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>214-09-4274</b>		17. INFORMANT <b>2617 S. Holbrook St. Fred Faughander Philadelphia, Pa.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>4200</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of left breast</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>none</b> 20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b> 20f. (City or town) (County) (State) <b>- - -</b>									
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>61</b> , to <b>Sept. 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept. 26</b> 19 <b>66</b> and that death occurred at <b>A</b> M., from the causes and on the date stated above.									
22a. SIGNATURE <b>Harold R. Ritch, Jr.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.O. <b>Dr. Harold R. Ritch, Jr.</b> 22d. ADDRESS <b>302 N. Potomac St Hagerstown, Md</b>			22b. DATE SIGNED <b>9-26-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Williamsport, Maryland</b>		
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport, Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 29 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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CENTRAL OF DEATH

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Washington County Hospital

126 Fairmount Ave.

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White

July 12, 1898

North Hill

Washington, Maryland

CHARLES FRANKLIN

AND GROCE

210-09-0274 The Washington National

possessive infidelity

Conjunctive heart failure

Arteriosclerotic heart disease

Carotid artery disease

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Aug. 29 1933

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Dr. Harold N. Smith

Sept. 22, 1933, Report of Community Will report, Maryland

Albert N. East, Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. LENGTH OF STAY IN 1b <b>4 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>650 OAK HILL AVE.</b>					
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>FRANKLIN</b> Last <b>FLEAGLE</b>						4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>14</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 22, 1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MERCHANT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>STORE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>SAMUEL J. FLEAGLE</b>						14. MOTHER'S MAIDEN NAME <b>FLORENCE H. SPAHR</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-32-5341</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. ETHEL FLEAGLE 650 OAK HILL AVE.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, Recurrent</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Atherosclerosis</b> DUE TO (c) <b>Hypertension with Vascular Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>1 year</b> <b>16 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> , 19 <b>47</b> to <b>9-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-14</b> , 19 <b>66</b> , and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dalton M. Welty</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY M.D.</b>						22d. ADDRESS <b>998 POTOMAC AVE. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/17/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MD.</b>			
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

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VR A15 (4)  
20M 1/65

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13323 CERTIFICATE OF DEATH 13317

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>16 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>626 Potomac Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>KATHRYN</b> Last <b>FLEMING</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12 1896</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fleming</b>		14. MOTHER'S MAIDEN NAME <b>Anna Nora Fleming</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-3799</b>	
17. INFORMANT <b>Miss Ethel M Rinehart</b>		<b>626 Potomac Ave. Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute broncho-spasm &amp; edema</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>68</b> , to <b>Sept 13</b> , 19 <b>66</b> , that (I) <b>over</b> last saw the deceased alive on <b>Sept 13</b> , 19 <b>66</b> , and that death occurred at <b>1P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>M. E. Byrkit</b>		22b. DATE SIGNED <b>9.15.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit, M. D.</b>		22d. ADDRESS <b>Williamsport Maryland 21795</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 15-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Williamsport Md.</b>
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>	
ADDRESS <b>Williamsport Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13324

13318

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN lb <u>42 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>625 Maryland Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Estie</u> Last <u>Johner</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Augusta County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Elyard</u>				14. MOTHER'S MAIDEN NAME <u>Mahalia Bolton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Wm. G. Johner</u> Address <u>625 Maryland Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS - GENERALIZED</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CARCINOMA OVARY</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>58</u> , to <u>SEPT 27</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>SEPT 27</u> , 19 <u>66</u> , and that death occurred at <u>8:10 PM</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>Archie Robert Cohen</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>09-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN M.D.</u>				22d. ADDRESS <u>CLEAR SPRING - MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Stark</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1931

STATE OF TEXAS

1931

Name of Person		Address		Occupation	
John Doe		123 Main St, Houston, TX		Teacher	
Jane Doe		456 Oak St, Houston, TX		Homemaker	
Bob Doe		789 Pine St, Houston, TX		Engineer	
Alice Doe		101 Elm St, Houston, TX		Nurse	
Frank Doe		202 Cedar St, Houston, TX		Farmer	
Grace Doe		303 Birch St, Houston, TX		Retailer	
Henry Doe		404 Spruce St, Houston, TX		Lawyer	
Irene Doe		505 Willow St, Houston, TX		Artist	
James Doe		606 Ash St, Houston, TX		Scientist	
Katherine Doe		707 Hickory St, Houston, TX		Writer	
Leo Doe		808 Sycamore St, Houston, TX		Musician	
Mary Doe		909 Magnolia St, Houston, TX		Dancer	
Nicholas Doe		1010 Dogwood St, Houston, TX		Chef	
Olivia Doe		1111 Redwood St, Houston, TX		Florist	
Peter Doe		1212 Juniper St, Houston, TX		Architect	
Quinn Doe		1313 Cypress St, Houston, TX		Journalist	
Robert Doe		1414 Fir St, Houston, TX		Politician	
Sara Doe		1515 Gum St, Houston, TX		Social Worker	
Thomas Doe		1616 Hemlock St, Houston, TX		Historian	
Uma Doe		1717 Linden St, Houston, TX		Designer	
Victor Doe		1818 Maple St, Houston, TX		Translator	
Wendy Doe		1919 Palm St, Houston, TX		Event Planner	
Xavier Doe		2020 Peach St, Houston, TX		Gardener	
Yvonne Doe		2121 Plum St, Houston, TX		Librarian	
Zoe Doe		2222 Rose St, Houston, TX		Photographer	
Adam Doe		2323 Strawberry St, Houston, TX		Videographer	
Bella Doe		2424 Tangerine St, Houston, TX		Fashion Designer	
Caleb Doe		2525 Vanilla St, Houston, TX		Chef	
Diana Doe		2626 Watermelon St, Houston, TX		Baker	
Ethan Doe		2727 Lemon St, Houston, TX		Butcher	
Fiona Doe		2828 Lime St, Houston, TX		Dairy Farmer	
Gavin Doe		2929 Orange St, Houston, TX		Fruit Farmer	
Hannah Doe		3030 Apple St, Houston, TX		Vineyard Owner	
Isaac Doe		3131 Grape St, Houston, TX		Winery Owner	
Julia Doe		3232 Berry St, Houston, TX		Food Processor	
Karl Doe		3333 Citrus St, Houston, TX		Food Distributor	
Lillian Doe		3434 Spice St, Houston, TX		Food Retailer	
Mason Doe		3535 Sugar St, Houston, TX		Food Manufacturer	
Nora Doe		3636 Honey St, Houston, TX		Food Importer	
Oscar Doe		3737 Butter St, Houston, TX		Food Exporter	
Pamela Doe		3838 Oil St, Houston, TX		Food Processor	
Quinn Doe		3939 Flour St, Houston, TX		Food Manufacturer	
Rory Doe		4040 Grain St, Houston, TX		Food Distributor	
Sally Doe		4141 Meat St, Houston, TX		Food Retailer	
Timothy Doe		4242 Fish St, Houston, TX		Food Manufacturer	
Uma Doe		4343 Seafood St, Houston, TX		Food Distributor	
Victor Doe		4444 Poultry St, Houston, TX		Food Retailer	
Wendy Doe		4545 Eggs St, Houston, TX		Food Manufacturer	
Xavier Doe		4646 Dairy St, Houston, TX		Food Distributor	
Yvonne Doe		4747 Produce St, Houston, TX		Food Retailer	
Zoe Doe		4848 Groceries St, Houston, TX		Food Manufacturer	
Adam Doe		4949 Pantry St, Houston, TX		Food Distributor	
Bella Doe		5050 Kitchen St, Houston, TX		Food Retailer	
Caleb Doe		5151 Dining St, Houston, TX		Food Manufacturer	
Diana Doe		5252 Living St, Houston, TX		Food Distributor	
Ethan Doe		5353 Bedroom St, Houston, TX		Food Retailer	
Fiona Doe		5454 Bathroom St, Houston, TX		Food Manufacturer	
Gavin Doe		5555 Hallway St, Houston, TX		Food Distributor	
Hannah Doe		5656 Staircase St, Houston, TX		Food Retailer	
Isaac Doe		5757 Attic St, Houston, TX		Food Manufacturer	
Julia Doe		5858 Basement St, Houston, TX		Food Distributor	
Karl Doe		5959 Garage St, Houston, TX		Food Retailer	
Lillian Doe		6060 Driveway St, Houston, TX		Food Manufacturer	
Mason Doe		6161 Front Yard St, Houston, TX		Food Distributor	
Nora Doe		6262 Back Yard St, Houston, TX		Food Retailer	
Oscar Doe		6363 Fence St, Houston, TX		Food Manufacturer	
Pamela Doe		6464 Mailbox St, Houston, TX		Food Distributor	
Quinn Doe		6565 Gate St, Houston, TX		Food Retailer	
Rory Doe		6666 Path St, Houston, TX		Food Manufacturer	
Sally Doe		6767 Walkway St, Houston, TX		Food Distributor	
Timothy Doe		6868 Stairs St, Houston, TX		Food Retailer	
Uma Doe		6969 Landing St, Houston, TX		Food Manufacturer	
Victor Doe		7070 Balcony St, Houston, TX		Food Distributor	
Wendy Doe		7171 Terrace St, Houston, TX		Food Retailer	
Xavier Doe		7272 Porch St, Houston, TX		Food Manufacturer	
Yvonne Doe		7373 Deck St, Houston, TX		Food Distributor	
Zoe Doe		7474 Patio St, Houston, TX		Food Retailer	
Adam Doe		7575 Lawn St, Houston, TX		Food Manufacturer	
Bella Doe		7676 Garden St, Houston, TX		Food Distributor	
Caleb Doe		7777 Trees St, Houston, TX		Food Retailer	
Diana Doe		7878 Flowers St, Houston, TX		Food Manufacturer	
Ethan Doe		7979 Fruits St, Houston, TX		Food Distributor	
Fiona Doe		8080 Vegetables St, Houston, TX		Food Retailer	
Gavin Doe		8181 Herbs St, Houston, TX		Food Manufacturer	
Hannah Doe		8282 Spices St, Houston, TX		Food Distributor	
Isaac Doe		8383 Oils St, Houston, TX		Food Retailer	
Julia Doe		8484 Vinegars St, Houston, TX		Food Manufacturer	
Karl Doe		8585 Condiments St, Houston, TX		Food Distributor	
Lillian Doe		8686 Dressings St, Houston, TX		Food Retailer	
Mason Doe		8787 Sauces St, Houston, TX		Food Manufacturer	
Nora Doe		8888 Pastes St, Houston, TX		Food Distributor	
Oscar Doe		8989 Powders St, Houston, TX		Food Retailer	
Pamela Doe		9090 Starches St, Houston, TX		Food Manufacturer	
Quinn Doe		9191 Flours St, Houston, TX		Food Distributor	
Rory Doe		9292 Grains St, Houston, TX		Food Retailer	
Sally Doe		9393 Beans St, Houston, TX		Food Manufacturer	
Timothy Doe		9494 Nuts St, Houston, TX		Food Distributor	
Uma Doe		9595 Seeds St, Houston, TX		Food Retailer	
Victor Doe		9696 Fruits St, Houston, TX		Food Manufacturer	
Wendy Doe		9797 Vegetables St, Houston, TX		Food Distributor	
Xavier Doe		9898 Herbs St, Houston, TX		Food Retailer	
Yvonne Doe		9999 Spices St, Houston, TX		Food Manufacturer	
Zoe Doe		10000 Oils St, Houston, TX		Food Distributor	

Wm. C. Hunt



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Rt. # 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hosp. (D.O.A.)</u>		d. STREET ADDRESS <u>Homewood Addition</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Forrest</u> Last <u>Folk</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>1,</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1933</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David J. Folk</u>		14. MOTHER'S MAIDEN NAME <u>Nina E. Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes,</u>		16. SOCIAL SECURITY NO. <u>217-28-9391</u>	
17. INFORMANT <u>Mr. David J. Folk</u>		Address <u>Rt. # 1 Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to chest and</u> <u>9123</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Abdomen, with Massive Internal</u> DUE TO (c) <u>Injuries</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 Min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck and crushed by Steam Roller</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:30 a.m. 9/1/66</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> <u>at work</u> <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route #40</u>		20f. (City or town) (County) (State) <u>Hancock Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>		22. DATE SIGNED <u>9/1/66</u>	
EXAMINER'S NAME (Type) <u>EDWARD W. DITTO, III M.D.</u> <u>217 W. WASHINGTON ST.</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/4/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hagerstown, Md.</u> <u>Restlawn Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>	
Address <u>Cumberland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1831

1831

EDWARD W. DITTO, III, M.D.  
317 W. WASHINGTON ST.  
JAGERSTOWN, MD.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>8 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>908 Hamilton Blvd.</b>		d. STREET ADDRESS <b>908 Hamilton Blvd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grover Lee Ford</b>		4. DATE OF DEATH Month Day Year <b>September 9, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1894</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11 17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway Mail Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mail</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md. Clevelandville, Wash. Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel Ford</b>		14. MOTHER'S MAIDEN NAME <b>Maria Haupt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W. W. One</b>		16. SOCIAL SECURITY NO. <b>578-50-5837</b>	
17. INFORMANT <b>Hagerstown, Md.</b>		18. ADDRESS <b>Mrs. Nellie Ford, 908 Hamilton Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute myocardial infarction</b> DUE TO (b) <b>Atherosclerotic (Coronary) Heart Disease</b> DUE TO (c) <b>9 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-29, 1959</b> , to <b>9-9, 1966</b> , that (I) (we) last saw the deceased alive on <b>9-9-1966</b> , and that death occurred at <b>130 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John H. Hornbaker, M.D.</b>		22b. DATE SIGNED <b>9-10-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13350

CONTINUATION OF DEATH

13350

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Manner of death		8. Occupation		9. Education		10. Marital status	
11. Name of informant		12. Relationship to deceased		13. Signature of informant		14. Date of report		15. Name of physician	
16. Name of funeral home		17. Name of cemetery		18. Name of burial place		19. Name of burial place		20. Name of burial place	
21. Name of burial place		22. Name of burial place		23. Name of burial place		24. Name of burial place		25. Name of burial place	
26. Name of burial place		27. Name of burial place		28. Name of burial place		29. Name of burial place		30. Name of burial place	
31. Name of burial place		32. Name of burial place		33. Name of burial place		34. Name of burial place		35. Name of burial place	
36. Name of burial place		37. Name of burial place		38. Name of burial place		39. Name of burial place		40. Name of burial place	
41. Name of burial place		42. Name of burial place		43. Name of burial place		44. Name of burial place		45. Name of burial place	
46. Name of burial place		47. Name of burial place		48. Name of burial place		49. Name of burial place		50. Name of burial place	
51. Name of burial place		52. Name of burial place		53. Name of burial place		54. Name of burial place		55. Name of burial place	
56. Name of burial place		57. Name of burial place		58. Name of burial place		59. Name of burial place		60. Name of burial place	
61. Name of burial place		62. Name of burial place		63. Name of burial place		64. Name of burial place		65. Name of burial place	
66. Name of burial place		67. Name of burial place		68. Name of burial place		69. Name of burial place		70. Name of burial place	
71. Name of burial place		72. Name of burial place		73. Name of burial place		74. Name of burial place		75. Name of burial place	
76. Name of burial place		77. Name of burial place		78. Name of burial place		79. Name of burial place		80. Name of burial place	
81. Name of burial place		82. Name of burial place		83. Name of burial place		84. Name of burial place		85. Name of burial place	
86. Name of burial place		87. Name of burial place		88. Name of burial place		89. Name of burial place		90. Name of burial place	
91. Name of burial place		92. Name of burial place		93. Name of burial place		94. Name of burial place		95. Name of burial place	
96. Name of burial place		97. Name of burial place		98. Name of burial place		99. Name of burial place		100. Name of burial place	

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13328

13322

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro Rfd. 2</b> d. STREET ADDRESS <b>Mapleville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Blanche May Gross</b>		4. DATE OF DEATH Month Day Year <b>September 20, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mapleville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Gantz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Elmer T. Gross, Boonsboro Rfd. 2, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Liver</b> DUE TO (b) <b>Embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 12, 1966</b> to <b>Sept 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1966</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. LeVan</b>		22b. DATE SIGNED <b>9/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-23-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13329 CERTIFICATE OF DEATH 13323									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b> 21-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>135 W. Main St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Elizabeth</b> Last <b>Gross</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2 1931</b>		9. AGE (In years last birthday) <b>35</b> yrs. IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitorial Service</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Mack Truck</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Shepherdstown, W. Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel F. Swope</b>					14. MOTHER'S MAIDEN NAME <b>Lottie Blanche Breeben</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214 28 7436</b>		17. INFORMANT <b>135 W. Main St.</b> <b>Mr. Gerald Gross Sharpsburg Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive subarachnoid hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>9-20-66</b> , 19 <b>66</b> , to <b>9-21-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-21-66</b> , 19 <b>66</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>A. F. Abdullah</b>								22b. DATE SIGNED <b>9-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. F. Abdullah, M. D.</b>					22d. ADDRESS <b>132 N. Potomac St., Hagerstown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Hagerstown Maryland</b>		
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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St. Louis

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13327		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Jefferson</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charles Town</b> d. STREET ADDRESS <b>Box 386</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Arthur Lee Grim</b> 4. DATE OF DEATH <b>Sept. 24, 1966</b>		5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>11/23/16</b> 9. AGE (In years last birthday) <b>49</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Groom</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Horse racing</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Esau Grim</b>		14. MOTHER'S MAIDEN NAME <b>Susie Lackey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clarence Grim, Berryville, Va.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration + pneumonia</b> DUE TO (b) <b>convulsive seizures + D.T.'s</b> DUE TO (c) <b>alcoholism, nerve &amp; chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>3 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>cerebral concussion</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dragged + thrown by a horse AT HAY. RACK TRUCK</b>	
20c. TIME OF INJURY Month, Day, Year <b>7 9/21 1966</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> <b>at work</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Race Track</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.N. WEEKS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>9/24/66</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/27/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Berryville, Virginia</b>	
24. FUNERAL DIRECTOR <b>Charles J. Enders - Berryville, Va.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>1 MONTH</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GARLOCK CONV. HOME</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>974 JEFFERSON BLVD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>FRANCIS</b>			First <b>JOSEPH</b>		Middle <b>HAMBURG</b>		Last <b>HAMBURG</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>20</b> Year <b>19 66</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 13, 1889</b>		9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACHINIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BLAIR CO., PENNA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>CHARLES F. HAMBURG</b>						14. MOTHER'S MAIDEN NAME <b>ANNA RENNETT</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>705-10-6577</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. JACK COMER 974 JEFFERSON BLVD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X Hypostatic pneumonia - due to</b> DUE TO (b) <b>Nephrosclerosis &amp; Advanced Arterio-</b> DUE TO (c) <b>sclerotic vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inguinal Hernia, Bilateral - @ Paget's Disease Pubis.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 yrs</b> <b>25 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 28</b> , 19 <b>66</b> , to <b>Sept 20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 20</b> , 19 <b>66</b> , and that death occurred at <b>5:20</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Edward W. Ditto, III</b>								22b. DATE SIGNED <b>9/21/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO, III, M.D.</b>								22d. ADDRESS <b>219 W. WASHINGTON ST. HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>SEPT. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b> <b>HAGERSTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

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502-01-288

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U. S. ARMY OFFICE OF CHARGE



## CERTIFICATE OF DEATH

Reg. Dist. No. 13325

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Loudoun</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lovettsville (Rural)</u>		<u>83-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD# 1, Lovettsville, Va.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u>		(Middle) <u>RICHARD</u>		(Last) <u>HARDING</u>		(Month) (Day) (Year) <u>Sept. 23, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 12, 1912</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if) <u>Truck Foreman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Harpers Ferry, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Marion Harding</u>				14. MOTHER'S MAIDEN NAME <u>Katie Mae Springer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>A-231-12-9345</u>		17. INFORMANT & ADDRESS <u>Mrs. Velma Harding RFD#1, Lovettsville, Va. 22080</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>pulmonary failure</u>						<u>weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>bronchogenic carcinoma</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>pleural effusion</u>						<u>2 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 7, 1966</u> to <u>Sept. 23, 1966</u> , that I last saw the deceased alive on <u>Sept. 23, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>John C. Stauffer</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 S. Prospect St., Hagerstown, Maryland</u>		DATE SIGNED <u>9-24-66</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/25/66</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bolivar, West Va.</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>		REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Eckles</u>		ADDRESS <u>Harpers Ferry West Va.</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom col-7 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

SMITHSONIAN INSTITUTION

RECEIVED AT THE NATIONAL MUSEUM, WASHINGTON, D. C. JANUARY 23 1966

1. Name of deceased: JAMES HARTON HARDING  
2. Date of death: JANUARY 23 1966  
3. Place of death: HARRISBURG, PENNSYLVANIA  
4. Cause of death: HEART DISEASE  
5. Age at death: 78 years  
6. Sex: Male  
7. Race: White  
8. Religion: Protestant  
9. Education: High School Graduate  
10. Occupation: Retired  
11. Social Security Number: 12-34-56789  
12. Marital Status: Married  
13. Name of spouse: MRS. VELMA HARDING  
14. Name of child: LILLIAN MARIE HARDING  
15. Name of child: JAMES HARTON HARDING  
16. Name of child: ROBERT L. HARDING  
17. Name of child: EUGENE L. HARDING  
18. Name of child: MARGARET L. HARDING  
19. Name of child: JUDITH L. HARDING  
20. Name of child: KATHLEEN L. HARDING  
21. Name of child: MICHAEL L. HARDING  
22. Name of child: CHRISTOPHER L. HARDING  
23. Name of child: JENNIFER L. HARDING  
24. Name of child: ALEXANDER L. HARDING  
25. Name of child: SARAH L. HARDING  
26. Name of child: BENJAMIN L. HARDING  
27. Name of child: ISABELLE L. HARDING  
28. Name of child: MATTHEW L. HARDING  
29. Name of child: CHARLOTTE L. HARDING  
30. Name of child: DAVID L. HARDING  
31. Name of child: ELIZABETH L. HARDING  
32. Name of child: JACOB L. HARDING  
33. Name of child: REBECCA L. HARDING  
34. Name of child: SIMON L. HARDING  
35. Name of child: LUCAS L. HARDING  
36. Name of child: HANNAH L. HARDING  
37. Name of child: ISAAC L. HARDING  
38. Name of child: GRACE L. HARDING  
39. Name of child: BENJAMIN L. HARDING  
40. Name of child: SARAH L. HARDING  
41. Name of child: DAVID L. HARDING  
42. Name of child: ELIZABETH L. HARDING  
43. Name of child: JACOB L. HARDING  
44. Name of child: REBECCA L. HARDING  
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48. Name of child: ISAAC L. HARDING  
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50. Name of child: BENJAMIN L. HARDING  
51. Name of child: SARAH L. HARDING  
52. Name of child: DAVID L. HARDING  
53. Name of child: ELIZABETH L. HARDING  
54. Name of child: JACOB L. HARDING  
55. Name of child: REBECCA L. HARDING  
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57. Name of child: LUCAS L. HARDING  
58. Name of child: HANNAH L. HARDING  
59. Name of child: ISAAC L. HARDING  
60. Name of child: GRACE L. HARDING  
61. Name of child: BENJAMIN L. HARDING  
62. Name of child: SARAH L. HARDING  
63. Name of child: DAVID L. HARDING  
64. Name of child: ELIZABETH L. HARDING  
65. Name of child: JACOB L. HARDING  
66. Name of child: REBECCA L. HARDING  
67. Name of child: SIMON L. HARDING  
68. Name of child: LUCAS L. HARDING  
69. Name of child: HANNAH L. HARDING  
70. Name of child: ISAAC L. HARDING  
71. Name of child: GRACE L. HARDING  
72. Name of child: BENJAMIN L. HARDING  
73. Name of child: SARAH L. HARDING  
74. Name of child: DAVID L. HARDING  
75. Name of child: ELIZABETH L. HARDING  
76. Name of child: JACOB L. HARDING  
77. Name of child: REBECCA L. HARDING  
78. Name of child: SIMON L. HARDING  
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90. Name of child: LUCAS L. HARDING  
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92. Name of child: ISAAC L. HARDING  
93. Name of child: GRACE L. HARDING  
94. Name of child: BENJAMIN L. HARDING  
95. Name of child: SARAH L. HARDING  
96. Name of child: DAVID L. HARDING  
97. Name of child: ELIZABETH L. HARDING  
98. Name of child: JACOB L. HARDING  
99. Name of child: REBECCA L. HARDING  
100. Name of child: SIMON L. HARDING

CERTIFICATE OF DEATH

1966

Form No. 10

1. Name of deceased: JAMES HARTON HARDING

2. Date of death: JANUARY 23 1966

3. Place of death: HARRISBURG, PENNSYLVANIA

4. Cause of death: HEART DISEASE

5. Age at death: 78 years

6. Sex: Male

7. Race: White

8. Religion: Protestant

9. Education: High School Graduate

10. Occupation: Retired

11. Social Security Number: 12-34-56789

12. Marital Status: Married

13. Name of spouse: MRS. VELMA HARDING

14. Name of child: LILLIAN MARIE HARDING

15. Name of child: JAMES HARTON HARDING

16. Name of child: ROBERT L. HARDING

17. Name of child: EUGENE L. HARDING

18. Name of child: MARGARET L. HARDING

19. Name of child: JUDITH L. HARDING

20. Name of child: KATHLEEN L. HARDING

21. Name of child: MICHAEL L. HARDING

22. Name of child: CHRISTOPHER L. HARDING

23. Name of child: JENNIFER L. HARDING

24. Name of child: ALEXANDER L. HARDING

25. Name of child: SARAH L. HARDING

26. Name of child: BENJAMIN L. HARDING

27. Name of child: ISABELLE L. HARDING

28. Name of child: MATTHEW L. HARDING

29. Name of child: CHARLOTTE L. HARDING

30. Name of child: DAVID L. HARDING

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72. Name of child: BENJAMIN L. HARDING

73. Name of child: SARAH L. HARDING

74. Name of child: DAVID L. HARDING

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95. Name of child: SARAH L. HARDING

96. Name of child: DAVID L. HARDING

97. Name of child: ELIZABETH L. HARDING

98. Name of child: JACOB L. HARDING

99. Name of child: REBECCA L. HARDING

100. Name of child: SIMON L. HARDING

## CERTIFICATE OF DEATH

13326

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN lb <b>10 hours</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		e. STREET ADDRESS <b>Harp Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRACE AMELIA HARP</b>		4. DATE OF DEATH Month Day Year <b>September 15 19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 15, 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Curtis Gouker</b>		14. MOTHER'S MAIDEN NAME <b>Annie Travers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Elmer L. Harp, Myersville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Arteriosclerotic cardiac Dis.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis Hypertension</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6 Sept</b> , 19 <b>66</b> , to <b>date</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>15 Sept 1966</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Richard T. Binford</b>		22b. DATE SIGNED <b>16 Sept 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>		22d. ADDRESS <b>135 POTOMAC AVE., HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 18, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion E.U.B.</b>		23d. LOCATION (City or Town) (County) (State) <b>Myersville Fred. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Paul F. Bittle</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>	
ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u> c. LENGTH OF STAY in lb <u>2 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Reeder Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Morgan</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Carrie E. Hawvermale</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>19 66</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1885</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Single</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (County & State, or foreign country) <u>Morgan County W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter E. Hawvermale</u>			14. MOTHER'S MAIDEN NAME <u>Matilda Ann Compton</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mrs Bessie Hancock, Silver Springs</u> Address <u>8003 Eastern Drive</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Weniordelebe cardiovascular disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> 19 <u>66</u> , to <u>Sept 12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 11</u> 19 <u>66</u> , and that death occurred at <u>2A</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>G. Whelan</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/13/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. Whelan</u>				22d. ADDRESS <u>Boonsboro, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/14/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spoehr Croos Rds. Cem.</u>			23d. LOCATION (City, town or county) <u>Berkeley Springs, W. Va.</u> (State) _____		
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Horne</u>				ADDRESS <u>W. Va. Berkeley Spg.</u>		25a. REC'D BY REGISTRAR <u>SEP 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

SEG 1





CERTIFICATE OF DEATH

13334

13328

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>10 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>2208 Virginia Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Margaret</b> Last <b>Hess</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1877</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Emmitsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hess</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Jane Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John H. Spangler</b>		Address <b>1106 Oak Hill Ave Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart failure</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>14 days</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 3</b> , 1966, to <b>Sept 12</b> , 1966, that (I) (we) last saw the deceased alive on <b>Sept 12</b> , 1966, and that death occurred at <b>2:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. A. Hoffman</b>		22b. DATE SIGNED <b>9/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hoyd A. Hoffman</b>		22d. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept 14, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc,</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	
ADDRESS <b>Hagerstown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

-586-

125

CERTIFICATE OF DEATH

13329

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro, Rfd. 2</b> d. STREET ADDRESS <b>Mt. Lena</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Roy Albert Hoffman</b>		4. DATE OF DEATH Month Day Year <b>September 1, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1913</b> 9. AGE (In years last birthday) <b>53 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Lena, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Albert M. Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Martha Lum</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-09-2389</b>	
17. INFORMANT <b>Mrs. Polly I. Hoffman, Rfd. 2, Boonsboro, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute arrhythmia prob ventricular fibr</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute myocardial infarction</b> DUE TO (c) <b>arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b> <b>1 + years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>previous myocardial infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>31 Aug, 19</b> , to <b>1 Sept, 19 66</b> , that (I) (we) last saw the deceased alive on <b>31 Aug, 19 66</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John C. Stauffer</b>		22b. DATE SIGNED <b>9-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>		22d. ADDRESS <b>145 S. Prospect St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-3-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13331

CERTIFICATE OF DEATH

13331

Name of Deceased		Date of Birth		Sex	
John A. Smith		Jan 15, 1900		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		Jan 20, 1950		Heart Disease	
Occupation		Marital Status		Burial Place	
Teacher		Married		St. John's Church	
Signature of Physician		Signature of Registrar		Signature of Witnesses	
[Signature]		[Signature]		[Signatures]	
Date of Certificate		Place of Death		County	
Jan 25, 1950		New York City		New York	

13336

## CERTIFICATE OF DEATH

13330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>5 Wood St</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGIE</u> Middle <u>IRENE</u> Last <u>HOOVER</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>74</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Chambersburg Franklin Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Shreiner</u>		14. MOTHER'S MAIDEN NAME <u>Eleanora Morett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Eleanor L. Hoover</u>		Address <u>5 Wood St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Dis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 yrs</u> <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1926</u> , to <u>Sept. 1966</u> , that (I) (we) last saw the deceased alive on <u>9/25/66</u> , and that death occurred at <u>5:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John L. Mortimer M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/30/66</u>
22c. PHYSICIAN'S NAME (Type) <u>John L. Mortimer</u>		22d. ADDRESS <u>Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1933

CERTIFICATE OF DEATH

1933

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
RELIGION: [illegible]  
MARRIAGE: [illegible]  
SIGNED: [illegible]  
DATE: [illegible]



13337

CERTIFICATE OF DEATH

13331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>600 Preston Road</b>	
3. NAME OF DECEASED (Type or print) <b>Rev. John Edward Kemp Horn</b>		4. DATE OF DEATH Month <b>September</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>21</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergymen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Horn</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Heyn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.I</b>		16. SOCIAL SECURITY NO. <b>216-46-3757</b>	
17. INFORMANT <b>Mrs Bess Horn</b>		Address <b>600 Preston Road Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Head of Pancreas</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-21-</b> , 19 <b>66</b> , to <b>9-21</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>9-21</b> , 19 <b>66</b> , and that death occurred at <b>8 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dalton M. Welty</b>		22b. DATE SIGNED <b>9/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b>		22d. ADDRESS <b>998 Potomac Avenue Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 26 1966</b>	
ADDRESS <b>Hagerstown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

1666

2551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
133338					133332				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>10 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Avalon Manor</b>					d. STREET ADDRESS <b>Rd 6</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELDEN LOCKWOOD KERNEY</b>					4. DATE OF DEATH <b>Sept. 3 19 66</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/1885</b>		9. AGE (In years last birthday) yrs. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>city clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>city gov.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Shepherdstown, W.Va</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>James W. Kerney</b>					14. MOTHER'S MAIDEN NAME <b>Alice A. Mask</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-09-6309</b>		17. INFORMANT <b>Mrs. T. Aubrey Kemp</b> Address <b>Hagerstown, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Malignancy of lungs</b> DUE TO (b) <b>poss bronchial cell</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>over 10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>carcinoma of tongue and bladder</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 to <b>death</b> , 19, that (I) (we) last saw the deceased alive on <b>3 Apr 1966</b> , and that death occurred at <b>5:20</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>John C. Stouffer</b>					22b. DATE SIGNED <b>9-6-66</b>			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stouffer, M.D.</b>					22d. ADDRESS <b>1145 S. Prospect St., Hagerstown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>		
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

26861

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>		c. LENGTH OF STAY IN 1b <b>years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knoxville</b>		d. STREET ADDRESS <b>Route 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Edgar Kidwell</b>		4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>19 66</b>		5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/6/1893</b>		9. AGE (In years last birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William H. Kidwell</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Phillips</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W.W.1</b>		16. SOCIAL SECURITY NO. <b>705-10-2736</b>		17. INFORMANT <b>Mrs. Josephine Kidwell, Knoxville, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion -</b> DUE TO (b) <b>Arteriosclerotic Heart Disease &amp;</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>20 yrs.</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>9/4/66</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/6/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Episcopal Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brownsville, Wash., Md.</b>		24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 7 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

*Edward W. Ditto, III*  
**DR. E.W.DITTO, III**

**217 W? WASH. ST.**  
**HAG. MD.**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

13333

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DR. E.W. CITTID, III  
217 W. W. 21. ST.  
CHICAGO, ILL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13334											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>112 ELM STREET</b>						d. STREET ADDRESS <b>112 ELM STREET</b>					
3. NAME OF DECEASED (Type or print) <b>FRANKLIN First Middle Last</b> <b>FRANKLIN SIMON KINDALL</b>						4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>19 66</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 7, 1928</b>		9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARK DEPT.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CITY HAGERSTOWN</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN L. KINDALL</b>						14. MOTHER'S MAIDEN NAME <b>ELLA M. SWOPE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-34-9810</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. HILDA KINDALL 112 ELM STREET</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's disease, abdominal with involvement of intestinal tract,</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 10, 1966</b> , to <b>Sept. 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 12, 1966</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>W. T. Layman, M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/14/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM T. LAYMAN M.D.</b>						22d. ADDRESS <b>PROFESSIONAL ARTS BLDG. HAG. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>SEPT. 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>SEP 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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CITY HARBOR, BOSTON, MASS.

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## CERTIFICATE OF DEATH

13335

1. PLACE OF DEATH COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b>		c. LENGTH OF STAY IN lb <b>10 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>107 N. Main St.</b>		d. STREET ADDRESS <b>107 N. Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>C.</b> Last <b>Kottler</b>		4. DATE OF DEATH Month <b>September 10,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ministry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Florin Lancaster Oc. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Micheal Kottler</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dennis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>218-34-3881</b>	
17. INFORMANT <b>Mrs. Rose K. Kottler, 107 N. Main St.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardio vascular disease</b> 443x DUE TO (b) <b>disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b></b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
23. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
25. (City or town) <b></b>		26. (County) <b></b>	
27. (State) <b></b>		28. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1966</b> to <b>Sept 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 6, 1966</b> , and that death occurred at <b>9 P</b> M, from causes and on the date stated above.	
29. SIGNATURE <b>G. W. LeVan</b>		30. DATE SIGNED <b>9-12-66</b>	
31. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		32. ADDRESS <b>Boonsboro, Ind.</b>	
33. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		34. DATE THEREOF <b>9-13-66</b>	
35. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		36. LOCATION (City or Town) <b>Boonsboro, Md.</b>	
37. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md</b>		38. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
39. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		40. DATE <b>SEP 15 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13333

CERTIFICATE OF DEATH

13333

Name of Deceased		Date of Birth		Sex	
Place of Birth		Date of Death		Time of Death	
Cause of Death		Place of Death		Manner of Death	
Occupation		Education		Religion	
Marital Status		Previous Illnesses		Medical History	
Signature of Physician		Signature of Registrar		Signature of Witness	
Date of Certificate		Place of Issuance		Authority	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13362					13336				
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>75 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>129 E. LEE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOUISE</b> Last <b>KRETZER</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>21</b> Year <b>19 66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/15/1872</b>		9. AGE (In years last birthday) <b>94</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED SMITH</b>					14. MOTHER'S MAIDEN NAME <b>? MOATS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. JOHN L. HENESY</b>		Address <b>HAGERSTOWN MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>thrombophlebitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 19 <b>61</b> , to <b>Sept 21</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 20</b> 19 <b>66</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Louis Bragg</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/25/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Louis Bragg</b>					22d. ADDRESS <b>580 North Hagerstown</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>9/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>		
24. FUNERAL DIRECTOR <b>W.J. Normant Hagerstown Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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232



## CERTIFICATE OF DEATH

13337

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro Rfd. 2</b> c. LENGTH OF STAY IN lb <b>15 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney Keedy Memorial Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>241 S. Mulberry St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gamma Lee Krider</b>		4. DATE OF DEATH Month Day Year <b>September 21, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1877</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>5 17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Funkstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Krider</b>		14. MOTHER'S MAIDEN NAME <b>Clara Shilling</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-09-7441</b>	
17. INFORMANT <b>Miss Anna M. Krider, Boonsboro Rfd. 2, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adrenocortical Crisis, Vascular Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pneumonia</b> DUE TO (c) <b>1892</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1966</b> to <b>Sept 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1966</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. Lellan</b>		22b. DATE SIGNED <b>9/24/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. Lellan</b>		22d. ADDRESS <b>Boonsboro, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-24-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

1933

CERTIFICATE OF DEATH

1933

Name of Deceased		Date of Birth		Sex	
John Doe		Jan 1, 1900		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		Jan 15, 1933		Heart Disease	
Occupation		Marital Status		Burial Place	
Teacher		Married		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witnesses	
[Signature]		[Signature]		[Signatures]	
Date of Certificate		Issued at		By	
Jan 15, 1933		New York City		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>KENNA</u> b. COUNTY <u>FRANKLIN</u>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN IT <u>1 DAY</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GREENCASTLE</u> <u>75-3</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. Co. Hospital</u>				d. STREET ADDRESS <u>39 LINDEN AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William J. KRINER</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>19 66</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/9/1885</u>		9. AGE (in years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Andrew KRINER</u>				14. MOTHER'S MAIDEN NAME <u>Alice MYERS</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>204-30-5154</u>				17. INFORMANT <u>Mrs. Paul Musselman - Greencastle, Pa.</u>				Address <u>RD 3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular</u> <u>4221</u> <u>ONE TO</u> Conditions, if any, which gave rise to immediate cause (b) <u>disease</u> (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>    </u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>    </u> p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1965</u> to <u>9/20/66</u> , that (I) (we) last saw the deceased alive on <u>9/20/66</u> , and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>W.C. Brewer</u> M.D. 22b. DATE SIGNED <u>9/21/66</u> 22c. PHYSICIAN'S NAME (Type) <u>W.C. Brewer</u> 22d. ADDRESS <u>Greencastle, Pa.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>9/23/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR Hill</u>				23d. LOCATION (City, town or county) (State) <u>GREENCASTLE, PA.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.G. Munch</u>				ADDRESS <u>Greencastle, Pa.</u>				25a. REC'D BY REGISTRAR <u>SEP 23 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1933

CERTIFICATE OF DEATH

1933



13345

CERTIFICATE OF DEATH

13339

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>30 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1908 Virginia Ave.</b>				d. STREET ADDRESS <b>1908 Virginia Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN CHARLES LANDIS</b>				4. DATE OF DEATH Month Day Year <b>Sept. 16, 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1899</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>York, York Cty., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Landis</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Ness</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>214-09-1550</b>		17. INFORMANT Address <b>Mrs. Margaret Landis, 1908 Virginia Ave Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary/disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 min.</b>  <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 16, 1966</b> , to <b>Sept. 16, 1966</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 16, 1966</b> , and that death occurred at <b>9:40 P.</b> M. from causes and on the date stated above.							
22a. SIGNATURE <i>B. B. Kneisley</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>				22d. ADDRESS <b>148 West Washington Street Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Williamsport Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Hagerstown Md</b>				25a. REC'D BY REGISTRAR <b>Andrew K. Coffman Funeral Home Inc</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1933

STATE OF TEXAS

1933

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.



CERTIFICATE OF DEATH

13340

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Woodbine</u>		d. STREET ADDRESS <u>Woodbine Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Edward Lee</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>9</u> - Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Cemetery Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm Lee</u>		14. MOTHER'S MAIDEN NAME <u>Louy Saylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>226-16-2363</u>	
17. INFORMANT <u>MRS. C. Blanche Lee - Woodbine, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) <u>this hospital</u> attended the deceased from <u>9-7-1966</u> to <u>9/9</u> , 19 <u>66</u> , that (1) <u>two</u> last saw the deceased alive on <u>9/9/1966</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>		22b. DATE SIGNED <u>Sept. 9, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Victor Ramos</u>		22d. ADDRESS <u>1500 Penna. Avenue Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Baptist Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1966</u>	
ADDRESS <u>Sylkesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

13347

13341

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>84 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Friendship Manor Nursing Home</b>		d. STREET ADDRESS <b>&amp; 739 S. Potomac St.</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE LUTHER LE FEVRE</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1882</b>
9. AGE (In years last birthday) yrs. <b>84</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H. LeFevre</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Wallick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-20-2993</b>	
17. INFORMANT <b>Nora S. LeFevre</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Inf.</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease (Severe Type)</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 17, 1962</b> to <b>Sept 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1966</b> , and that death occurred at <b>5 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>9-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. KNEISLEY</b>		22d. ADDRESS <b>148 W. Washington St. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9/23/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 26 1966</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

354

WILLIAM COLLIER

WILLIAM B. LEEVER

EPPS-GS-PCS

• **Harvest** •

1997-1998

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13348

CERTIFICATE OF DEATH

13342

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waynesboro 75-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>R. D. 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marshall L. Mentzer</u>				4. DATE OF DEATH Month Day Year <u>Sept. 30 19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1908</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Fulton Co., Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Repair</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mack Truck</u>			
13. FATHER'S NAME <u>Ulysses G. Mentzer</u>				14. MOTHER'S MAIDEN NAME <u>Alice Gordon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>176-01-5419</u>		17. INFORMANT <u>Mrs. Marshall L. Mentzer</u> Address <u>Waynesboro #2, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X</u> DUE TO <u>Intubation, twice</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>later</u> DUE TO (c) <u>later</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Left Kidney Arteriovenous Heart Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-70</u> , 19 <u>65</u> , to <u>Sept 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> , 19 <u>66</u> , and that death occurred at <u>1:50 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>E. R. Larchezabal</u>				22b. DATE SIGNED <u>10-1-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. R. Larchezabal</u>				22d. ADDRESS <u>307 E. Larchezabal, Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Greencastle, Franklin, Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter J. Goss</u> ADDRESS <u>Waynesboro, Penna.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

5188

3322



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Friendship Manor Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#2</b> d. STREET ADDRESS <b>Conocheague</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLARA BELL MILLER</b>		4. DATE OF DEATH Month <b>September</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 8 1879</b>
9. AGE (In years lost birthday) yrs. <b>86</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Indian Springs Wash Co Md.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indian Springs Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Grove</b>		14. MOTHER'S MAIDEN NAME <b>Susan Pine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Earl S. Miller Hagerstown Md R #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> DUE TO (b) <b>Hypertensive Cardiovascular Dis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-16</b> , 19 <b>66</b> , to <b>9-13</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>9-12</b> , 19 <b>66</b> , and that death occurred at <b>10:20</b> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <b>Robert P. Conrad</b>		22b. DATE SIGNED <b>9-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad, MD</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>near Claer Spring Wash Co Md</b>
24. FUNERAL DIRECTOR <b>Hagerstown Md.</b> <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

13313

CENTRAL OF TEXAS

13313

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13350

13344

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washingt on</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>19 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Springs R # 1</b>		<b>21-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Cress Pond Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SIMON GEORGE MILLER</b>				4. DATE OF DEATH Month Day Year <b>Sept. 23 1966 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 13 1875</b>	
9. AGE (In years last birthday) <b>91 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Everett Bedford Co Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Franklin P. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Isabelle Barndollar</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>18-24-9295</b>		17. INFORMANT Address <b>Elmer R. Miller Cress Pond Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive gastric Intestine?</b> 2040 DUE TO Hemorrhage - due Lymphocytic Leukemia & Thrombocytopenia (b) <b>Unknown</b> DUE TO (c)		Clear Spring MD R #1		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>generalized Arteriosclerosis, Severe</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1966</b> , to <b>Sept 23, 1966</b> , that (I) (we) lost saw the deceased alive on <b>Sept 23, 1966</b> , and that death occurred at <b>7:15 P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Edward W. Ditto III</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/26/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		22d. ADDRESS <b>217 West Washington Street Hag., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Hagerstown Md. ADDRESS</b> <b>Andrew K. Coffman Funeral Home Inc</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					b. COUNTY Washington				
c. LENGTH OF STAY IN 1b 10 Days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Big Spring, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS R.F.D.1				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Winfield Albert Mills					4. DATE OF DEATH Month Day Year Sept 9 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1909		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Mercersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Mills					14. MOTHER'S MAIDEN NAME Lizie Stoner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 212-24-5441				
17. INFORMANT Hazel Mills					Address Big Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Carcinoma of Colon DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH 4 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-16-66, 1966, to 9/9, 1966, that (I) (we) last saw the deceased alive on 9/9, 1966, and that death occurred at 3:55 AM, from the causes and on the date stated above.									
22a. SIGNATURE J. R. Dwyer					22b. DATE SIGNED 9/10/66			22c. PHYSICIAN'S NAME (Type) J. R. Dwyer	
22d. ADDRESS 119 King St Hagerstown Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept 12, 66		23c. NAME OF CEMETERY OR CREMATORY Clear Spring Mennonite		23d. LOCATION (City, town or county) (State) Clear Spring, Md.		
24. FUNERAL DIRECTOR Donald E. Thompson					25a. REC'D BY REGISTRAR DATE SEP 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1881

CERTIFICATE OF DEATH

1881



*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a form with multiple sections, possibly containing personal details, a medical history, and a signature area. Some words like "Name", "Age", "Sex", and "Cause of Death" might be discernible in certain sections.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

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13352

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2c & d Film #G380 9/16/66

13346

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Boonsboro</b>		c. LENGTH OF STAY IN lb <b>5 years</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney-Keedy Memorial Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>J.</b> Last <b>MINNICH</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>19 66</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1878</b>	
9. AGE (In years lost birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Luther M. Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Barbara E. Kershner</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		
17. INFORMANT <b>Marryatt Watkins, Chicago, Ill</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> <b>auricular fibrillation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Indefinite</b>				INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis generalized</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year <b>Hour a.m. p.m. 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>death</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>8-8</b> 19 <b>66</b> , and that death occurred at <b>200P</b> M, from causes on and on the date stated above.				
22a. SIGNATURE <b>Robert F. Keedy</b> M.D.		22b. DATE SIGNED <b>9-7-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>ROBERT F. KEEDY</b>		22d. ADDRESS <b>Hagerstown Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-7-66</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>		
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

13340

UNITED STATES

13340

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some handwritten notes are visible on the left margin.]*


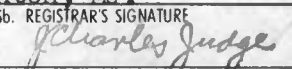
13353

CERTIFICATE OF DEATH

13347

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>D. O. A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Fairplay Rfd. 1</b>	
3. NAME OF DECEASED (Type or print) <b>Mary S. Mongan</b>		4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1895</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tilghmanton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Franklin Mongan</b>		14. MOTHER'S MAIDEN NAME <b>Emma Rohrer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Jeremiah Mongan, Fairplay Rfd. 1, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>0 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 24</b> , 19 <b>58</b> , to <b>Sep 23</b> , 19 <b>66</b> that (I) <del>was</del> last saw the deceased alive on <b>Aug 28</b> , 19 <b>66</b> , and that death occurred at <b></b> M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>Sept 26, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit</b>		22d. ADDRESS <b>Williamsport Maryland 21795</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-27-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Tilghmanton, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 29 1966</b>	
		25b. REGISTRAR'S SIGNATURE 	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13354

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13348

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>315 Vale St.</u>	
3. NAME OF DECEASED (Type or print) <u>Solie Martin Mongan Sr.</u>		4. DATE OF DEATH <u>September 19 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1905</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor Operator</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Douglas Mongan</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Host</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-01-3028</u>	
17. INFORMANT <u>Mr. Solie Mongan Jr.</u>		Address <u>R # 2 Smithsburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 Congestive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sev. days</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <u>580 Northern Ave. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md</u>
24. FUNERAL DIRECTOR <u>Wm. A. Host</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1966</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13349

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge rural</b>	
c. LENGTH OF STAY IN 1b <b>Several hrs</b>		d. STREET ADDRESS <b>10-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			
3. NAME OF DECEASED (Type or print) <b>Alton Monroe Myers, Jr.</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1948</b>
9. AGE (in years last birthday) <b>17 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>17</b> Hours <b>48</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alton M. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Edith Penwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-50-7236</b>	
17. INFORMANT <b>Alton M. Myers</b>		Address <b>Rocky Ridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of Gastric Contents - due</b> 9133 DUE TO <b>Laceration of Brain and Blood Vessels</b> (b) <b>Cerebral edema and Compression</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hr.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Nail from Stud gun ricocheted penetrating Brain</b>	
20c. TIME OF INJURY Month, Day, Year <b>9-26 19 66</b> Hour, a.m. <b>2:00</b> p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital Bldg</b>	20f. (City or town) (County) (State) <b>Frederick Fred. Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edmund W. Dittus III</b>		22. DATE SIGNED <b>9-26-66</b>	
EXAMINER'S NAME (Type) <b>212 W. Washington St Hagerstown, Md</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-1-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Woodsboro Fred. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Raymond E. Greager</b>		25a. REC'D BY REGISTRAR <b>Thurmont, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 3 1966</b>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>301 S. Mont Valla Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Salvatore</u> Middle <u>NMN</u> Last <u>Nesi</u>		4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Lechi, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leo Nesi</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ponzro</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>705-14-0010</u>	
17. INFORMANT <u>Frank S. Nese</u>		Address <u>303 South Mont Valla Ave Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a); (b); and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 d</u> <u>unkn</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis, diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1966</u> , to <u>Sept 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 11, 1966</u> , and that death occurred at <u>3:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. L. Packer Jr</u>		22b. DATE SIGNED <u>9/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr</u>		22d. ADDRESS <u>145 W. Washington Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept, 14, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>	
ADDRESS <u>Hagerstown, Maryland.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>810 INTERVAL ROAD</b>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <b>THEODORE</b> Middle <b>W.</b> Last <b>PETERS</b>						4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>28</b> Year <b>19 66</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 11, 1887</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PRODUCE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>UNKNOWN</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>219-01-8635 A</b>		17. INFORMANT Address <b>WELFARE BOARD HAGERSTOWN, MARYLAND</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>												INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8 yrs. +</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <b>9/26, 1966</b> , to <b>9/28, 1966</b> , that (I) (we) last saw the deceased alive on <b>9/28 1966</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Frank F. Shupp</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>9/30/1966</b>													
22c. PHYSICIAN'S NAME (Type) <b>FRANK F. SHUPP M.D.</b> 22d. ADDRESS <b>109 1/2 N. POTOMAC ST. HAGERSTOWN, MD.</b>													
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/1/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>					
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>OCT 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

210 INTERIOR ROAD

WASHINGTON COUNTY HOSPITAL

THROCKMORTON

WELLS

WELLS

JAN. 11, 1927

WHITE

MALE

POTOMAC

LAGER

HARTLAND

UNKNOWN

UNKNOWN

210-01-935-A, HIGHER BOWEN, HARTLAND



9/30/1926

1007 N. POTOMAC ST. WASHINGTON, D.C.

ELLEN E. SHIPLEY

1007 N. POTOMAC ST.

10/1/1926

BIRTH

HARTLAND, WASHINGTON

CHARLES M. ROBERT, HARTLAND



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>HAGERSTOWN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>YORK</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>YORK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSP. D.O.A.</u>								d. STREET ADDRESS <u>908 CLAYTON AVE</u>			
3. NAME OF DECEASED (Type or print)		First <u>DONALD</u>		Middle <u>G.</u>		Last <u>PHILIPS</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-1908</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>EAST BERLIN, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID</u>						14. MOTHER'S MAIDEN NAME <u>BESSIE MCINTIRE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>115-10-0390</u>		17. INFORMANT <u>ESTELLA S. PHILIPS</u>		Address <u>908 CLAYTON AVE. YORK PA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>occlusion Right Coronary Artery</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Marked hypertrophy + dilatation of Right + Left Ventricle</u> (c) <u>Advanced Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH <u>15 Hrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>				M.O. <u>  </u>				22. DATE SIGNED <u>10-1-66</u>			
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>				Address (Street, city, town, or county) <u>Hagerstown, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-3-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MONUMENTS CEM.</u>				23d. LOCATION (City, town or county) (State) <u>ADAMS PA.</u>			
24. FUNERAL DIRECTOR <u>Wm. K. Dodson Jr.</u>				ADDRESS <u>511 N. GEORGE ST. YORK PA.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13359									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>15 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown, Md. R.R.#6</u> d. STREET ADDRESS <u>21-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Livingston</u> Last <u>Pinney</u>					4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-97</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frostburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank Whetstone</u>					14. MOTHER'S MAIDEN NAME <u>Mollie Street</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-1823</u>		17. INFORMANT <u>Chauncey S. Pinney Hagerstown, Md. R.R.#6</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinoma of Breast</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6-2-1966</u> to <u>9-24-1966</u> that (I) (we) last saw the deceased alive on <u>9-24-1966</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Frank Riego</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>9-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK RIEGO</u>					22d. ADDRESS <u>1500 Penna. Ave., Hagerstown</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. G. Hoot</u> <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md</u>					25a. REC'D BY REGISTRAR <u>SEP 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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CERTIFICATE OF DEATH

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13354

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>205 Division Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Rich</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas M. Rich</b>		14. MOTHER'S MAIDEN NAME <b>Jo Ann Kester</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Thomas M1 Rich, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mosses atelectasis</b> DUE TO <b>Pneumonia (1 lb 15 oz)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/25/1966</b> to <b>9/25/1966</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>9/25/1966</b> , and that death occurred at <b>11:45 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. M. Bacon, Jr.</b>		22b. DATE SIGNED <b>9/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. M. Bacon, Jr. M.D.</b>		22d. ADDRESS <b>101 King Street, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9-26-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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202 Division Ave.

Washington County Hospital

Sept. 22

May 20, 1910

Sept. 22, 1910

white

Washington, Md.

to Ann Kestor

Thomas M. Rich

Thomas M. Rich, Washington, Md.

Washington, Md.

Rose Hill Cemetery

7-25-20

Child

Washington General Home, Washington, Md.



## CERTIFICATE OF DEATH

13361

13355

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Greencastle R # 1</b>	
3. NAME OF DECEASED (Type or print) First <b>GENEVIEVE</b> Middle <b>MARY</b> Last <b>RZOMP</b>		4. DATE OF DEATH Month <b>September</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7 1919</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>15</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Brenizar Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Stanley Olclakowski</b>		14. MOTHER'S MAIDEN NAME <b>Stella Wisniewski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No..</b>		16. SOCIAL SECURITY NO. <b>178-20-0201</b>	
17. INFORMANT <b>Casimir H. Rzomp</b>		Address <b>R#1 Greencastle PA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 9, 1966</b> , to <b>Sept 19, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 19, 1966</b> , and that death occurred at <b>4:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Moran</b>		22b. DATE SIGNED <b>Sept 19, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>John A. Moran</b>		22d. ADDRESS <b>215 W. Washington St Hagerstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/22/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>E.S. Simon &amp; Jude Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Blairsville Indiana Pa</b>
24. FUNERAL DIRECTOR <b>Hagerstown Md. Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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## CERTIFICATE OF DEATH

13356

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>2428 Jefferson Blvd.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THELMA</b> Middle <b>ELIZABETH</b> Last <b>SENSENBAUGH</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1911</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>public school</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Smithsburg, Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George E. Winders</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Shank</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-36-3807</b>	17. INFORMANT <b>Glenn Sensenbaugh</b> Address <b>Hagerstown, Md</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent adenocarcinoma of the stomach</b> <b>1508</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of abdomen</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic bronchitis, Chronic</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 14</b> , 19 <b>50</b> to <b>Sept 2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 2</b> , 19 <b>66</b> , and that death occurred at <b>8:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE SIGNED <b>9/3/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b> ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>SEP 7 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and supply event, within 72 hours after death.

13333

CERTIFICATE OF DEATH

13333

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>12 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>64 NORTH AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>ROSS</b> Middle <b>DALE</b> Last <b>SHINDLE</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>19 66</b>								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/14/1909</b>		9. AGE (In years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR: Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED STOCKMAN</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM E. SHINDLE</b>					14. MOTHER'S MAIDEN NAME <b>ALICE EICHELBERGER</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>705-10-5439</b>		17. INFORMANT Address <b>HAGERSTOWN MD.</b> <b>MRS. LAURA B. SHINDLE</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>rupture of intraventricular septum</b> 4201 DUE TO (b) <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>arteriosclerotic heart disease</b> 4da, 4 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>paralysis agitans</b>								INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>9/3, 1966</b> , to <b>death</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>24 Sept 19 66</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>John C. Stauffer</b>					22b. DATE SIGNED <b>9-26-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>					22d. ADDRESS <b>1145 S. Prospect St., Hagerstown, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>9/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEAUTIFUL VIEW CEM.</b>		23d. LOCATION (City, town or county) (State) <b>STATE LINE MD.</b>				
24. FUNERAL DIRECTOR <b>W. J. Korman, Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 29 1966</b> DATE <b>SEP 29 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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HAGERSTOWN

WASHINGTON COUNTY HOSPITAL

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DAIS

GRINDLE

SHREVEPORT LA 70450

WHITE

10/1/1900

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HETTING STOCKMAN

RAIL ROAD

MARYLAND

U.S.A.

WILLIAM E. SHINDLE

ALICE SHINDLE

HAGERSTOWN

MD

702-10-2-39

MRS. LAURA E. SHINDLE

MD.

John J. Shannon

125 S. 1st St., Hagerstown, Md.

BUTLER

9/27/30

DEPARTMENT OF AGRICULTURE

STATE LINE

10 7 1/2 miles



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SMITHSBURG</b> c. LENGTH OF STAY IN 1b <b>10 YR</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>39 E. WATER ST.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SMITHSBURG</b> d. STREET ADDRESS <b>39 E. WATER ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BRUCE HARRY SHOCKEY</b>		4. DATE OF DEATH Month Day Year <b>SEPT. 1 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 19, 1914</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ROBERTSVILLE, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BRUCE SHOCKEY</b>		14. MOTHER'S MAIDEN NAME <b>NETTIE MCCARNEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>173-03-3580</b>	
17. INFORMANT <b>ELAINE SHOCKEY</b>		Address <b>SMITHSBURG</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>German Thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> to <b>Sept 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 1, 1966</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Geo G. Kohler</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>G. A. KOHLER</b>		22b. DATE SIGNED <b>Sept 1, 1966</b> 22d. ADDRESS <b>Smithsburg Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/3/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GREEN HILL</b>		23d. LOCATION (City, town or county) (State) <b>WAYNESBORO, PA.</b>	
24. FUNERAL DIRECTOR <b>W. T. Norment</b>		25a. REC'D BY REGISTRAR <b>Hog. Ind</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>SEP 6 1966</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN lb <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>25 1/2 W. Franklin St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Leon</u> Last <u>Sisler</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 13, 1949</u> 17
9. AGE (In years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Form Setter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Pipe Mfg.</u>	11. BIRTHPLACE (State or foreign country) <u>Keedysville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Francis E. Sisler Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Mildred May Wolfe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>212-50-9986</u>		17. INFORMANT <u>Francis E. Sisler Sr.</u> Address <u>Hagerstown, Md.</u> <u>1020 1/2 Corbett St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain stem injury (lac.)</u> DUE TO (b) <u>trauma</u> DUE TO (c) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. was thrown from car in a collision, Rt. 11, Marlowe, W. Va.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:30</u> p.m. <u>9/17</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Marlowe, W. Va.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22. DATE SIGNED <u>9/19/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/22/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown</u> <u>Wash.</u> <u>Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horn</u> ADDRESS <u>Rest Haven Funeral Chapel, Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 21 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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## CERTIFICATE OF DEATH

13360

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>8 MOS. 12 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND HOSPITAL</b>		d. STREET ADDRESS <b>R.D.# 2</b>	
3. NAME OF DECEASED (Type or print) First <b>Nannie</b> Middle <b>MAE</b> Last <b>Skelton</b>		4. DATE OF DEATH Month <b>9</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-29-01</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILBUR SKELTON</b>		14. MOTHER'S MAIDEN NAME <b>MARY BELLE DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HAGERSTOWN, MARYLAND</b>		<b>MR. LEONARD SHOEMAKER 145 N. AVENUE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>S</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>9 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-28, 1966</b> to <b>9-10, 1966</b> that (I) (we) last saw the deceased alive on <b>9-10 1966</b> and that death occurred at <b>4:45 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arturo Riego</b>		22b. DATE SIGNED <b>9/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arturo RIEGO</b>		22d. ADDRESS <b>1500 Penn. Ave., Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9/13/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN MARYLAND</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13367

CERTIFICATE OF DEATH

13361

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>6 Hr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lisa Marie Smith</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>	
13. FATHER'S NAME <b>Robert L Smith</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Feigley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Robert L Smith</b>		Address <b>Cress Pond Road Clearspring, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7592</b> <b>Congenital abnormality of diaphragm with herniation of abdominal contents into left thorax with resultant atelectasis of lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/16/66</b> to <b>9/16/66</b> , that (I) (we) last saw the deceased alive on <b>9/16/66</b> and that death occurred at <b>4:30 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks, M.D.</b>		22b. DATE SIGNED <b>9/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>580 Northern Ave. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md. Wash Co</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>	
ADDRESS <b>Hagerstown, Maryland.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13361

CONFIDENTIAL

13361

CONFIDENTIAL

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13368

Item #2d Film #G380 9/16/66 pc

13362

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>56 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Coffman Home for the Aging</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>Sept. 10,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1874</b>
9. AGE (In years lost birthday) yrs. <b>92</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>24</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ignatus H. Kimmelman</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Pfaff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-8062</b>	
17. INFORMANT <b>J. Paul Smith, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>447X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vasc. Disease</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>18 yrs</b> <b>18 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb</b> , 19 <b>48</b> , to <b>Sept 10</b> , 19 <b>66</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>Sept 10</b> , 19 <b>66</b> , and that death occurred at <b>5:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Clara A. Hoffman</b>		22b. DATE SIGNED <b>9/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>		22d. ADDRESS <b>214 N. Potomac St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

13382

13382

Washington

10 years

Golfman Home for the Blind

MARY ELIZABETH SMITH

Female white

March 16, 1874

Ignatius H. Kimmelmann

111-02-8082 J. Paul Smith, Baltimore, Md.

111-02-8082

Ignatius H. Kimmelmann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL- Williamsport</b> d. STREET ADDRESS <b>Williamsport, Md. RFD #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>MAXWELL</b> Last <b>SNYDER</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>10</b> Year <b>19 66</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>June 25, 1906</b>		9. AGE (In years last birthday) <b>60</b> yrs. IF UNDER 1 YEAR Months <b>3</b> Days <b>18</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. R.R.</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Wash. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Isaac Snyder</b>					14. MOTHER'S MAIDEN NAME <b>Maude E. Renner</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-01-9837</b>		17. INFORMANT <b>Mr. Joseph M. Snyder Williamsport RFD 2 Pinesburg, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute liver failure</b> <b>1561</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of liver (anaplastic)</b> (c) <b>Secondary Cirrhosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>8-31</b> , <b>1966</b> , to <b>9-10</b> , <b>1966</b> , that (I) (we) last saw the deceased alive on <b>9-9</b> , <b>1966</b> , and that death occurred at <b>WISAM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>G. Mr. Mandell</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-10-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>A. M. MANDELL MD</b>					22d. ADDRESS <b>119 E. ANTIETAM ST. HAC.</b>						
23a. BURIAL CREMATION (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Williamsport, Maryland</b>				
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>					ADDRESS <b>Williamsport, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Columbia Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State</b>		d. STREET ADDRESS <b>7612 Ridge Drive</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS HOWARD SNYDER</b>		4. DATE OF DEATH <b>Sept. 5, 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 2, 1911</b>
9. AGE (In years, lost birthday) yrs. <b>55</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas J. Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>412-16-9295</b>	
17. INFORMANT <b>June C. Funk- 7627 Greenleaf Road</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>lobular pneumonia</b> DUE TO (b) <b>cerebral thrombosis</b> DUE TO (c) <b>Hypertension</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>333X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Arteriosclerotic heart disease (2) Septicemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>April 26, 1966</b> to <b>Sept. 5, 1966</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>Sept. 5, 1966</b> , and that death occurred at <b>7:58 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Sister L. Ramos, M.D.</b>		22b. DATE SIGNED <b>Sept. 5, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>Sept 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia</b>	23d. LOCATION (City or Town) (County) (State) <b>Frederick Co. Va.</b>
24. FUNERAL DIRECTOR <b>Harold M. Bogant - Winchester Va.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13381

UNITED STATES OF AMERICA

13370

Washington

Washington

Columbia Heights

Columbia Heights

12 1/2 High Drive

Western Ave. at 21st

Thomas Lawrence Snyder  
Feb 2 1942

Paterson  
Paterson

Thomas O. Snyder  
Paterson

Line 2 East - 17th Street  
Paterson

Robert Henderson  
Paterson

Hypocenter  
Paterson

Carroll County (Paterson) (Paterson)

April 25 1942  
Sept 27 1942

Victor L. Kinner  
Victor L. Kinner

Paterson  
Paterson

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>										
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Washington</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>One month</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>Williamsport, Md. RFD #1</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ELIZABETH</u> Middle <u>WOLFORD</u> Last <u>SOCKS</u>					<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>7</u> Year <u>1966</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>B. DATE OF BIRTH</b> <u>Oct. 2, 1900</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <u>11</u> Months <u>5</u> Days <u></u> Hours <u></u> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Charwomen</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hotels</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Earl Moats</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Wolford</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <u>214-14-6054</u>		<b>17. INFORMANT</b> <u>Mr. Charles Edgar Socks</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURE OF LEFT VENTRICLE WITH CARDIAC TAMPONADE</u> 4201 DUE TO MYOCARDIAL INFARCTION, ANTERIOR APICAL REGION, Conditions, if any, which gave rise to immediate (b) <u>FRESH -- THROMBOTIC OCCLUSION OF ANTERIOR DESCENDING LEFT CORONARY ARTERY (RECENT WITH FRESH</u> cause (a), stating the underlying cause last. (c) <u>PROPAGATION) FRACTURED FEMUR</u>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 HRS.</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>FELL IN HOME</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>4:20 p.m. Aug. 10 1966</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>WILLIAMSPORT WASH.</u>		<b>(County)</b> <u>MD.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
<b>ACTUAL SIGNATURE</b> <u>Dr. E. W. Ditto</u>					<b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <u>DR. E. W. DITTO, JR. M.D.</u>					<b>22. DATE SIGNED</b> <u>SEPT. 8, 1966</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>					<b>23b. DATE THEREOF</b> <u>Sept. 10, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bakersville Cemetery Bakersville, Md.</u>		<b>23d. LOCATION (City, town or county)</b> <u>(State)</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Albert L. Leaf Williamsport, Md.</u>					<b>25a. REC'D BY REGISTRAR</b> <u>SEP 13 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

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FOR STATE  
HEALTH DEPT.

13372

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13366

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Spring, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Williamsport Maryland</b>		d. STREET ADDRESS <b>R.F.D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harold</b>		First Middle Lost <b>Gene Stevens</b>		4. DATE OF DEATH Month Day Year <b>Sept. 2nd 1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Dec. 23, 1937</b>		9. AGE (in years at birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>28</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brick Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Lauren Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Louise Shaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-34-7369</b>		17. INFORMANT <b>Patricia Stevens</b> Address <b>Big Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of chest</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ <b>919.8</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>20b. while removing 0.22 rifle from auto, man pulled trigger - firing gun - Bullet struck Mr. Stevens 100 yds away.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Pulled trigger of 0.22 rifle from auto</b>		20c. TIME OF INJURY Month, Day, Year Hour <b>9:50</b> p.m. <b>Sept 3, 1966</b>	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) (County) (State) <b>Williamsport Wash Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>9-3-66</b>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 5, 66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shanktown</b>	
24. FUNERAL DIRECTOR <b>Donald E. Thompson</b>		ADDRESS <b>Clear Spring Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 8 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
ZOM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>209 MEALEY PKWY.</b>					
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>KIEFFER</b> Last <b>STICKELL</b>						4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>15</b> Year <b>19 66</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 25, 1884</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED OFFICIAL</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GRAIN MILL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DANIEL A. STICKELL</b>						14. MOTHER'S MAIDEN NAME <b>LAURA MIDDLEKAUFF</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-09-6372</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MARGARET STICKELL 209 MEALEY PKWY.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1913</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous Cell Carcinoma of face</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>2 1/2 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>AUG.</b> , 19 <b>55</b> , to <b>SEPT. 15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 15</b> , 19 <b>66</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Lloyd A. Hoffman</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>LLOYD A. HOFFMAN M.D.</b>						22d. ADDRESS <b>214 N. POTOMAC ST. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/19/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13374 CERTIFICATE OF DEATH 13308											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VIRGINIA</b> b. COUNTY <b>BERKLEY</b> ✓						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL HEDGESVILLE</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>426 SUMMIT AVENUE</b>					d. STREET ADDRESS <b>R.D.# 1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>RUTH</b>		Middle <b>BAIRD</b>		Last <b>STONE</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>1</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 11, 1897</b>		9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN RHODES</b>					14. MOTHER'S MAIDEN NAME <b>FLORENCE HEMPHILL</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>216-14-6165</b>		17. INFORMANT <b>HAGERSTOWN, MD. RALPH SODERGREN 122 N. COLONIAL DR.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Essential Hypertension</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr</b> <b>2 yrs</b> <b>4 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>65</b> to <b>9/1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/19</b> , 19 <b>65</b> , and that death occurred at <b>12:00 P.M.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald E. Martin</b>					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <b>DONALD E. MARTIN M.D.</b>					22b. DATE SIGNED <b>9/2/1966</b>						
22d. ADDRESS <b>418 N. POTOMAC ST. HAGERSTOWN, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/3/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>				
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>4 Hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville, 21-1</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>6 Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Lauran</b> Last <b>Stotler Sr.</b>		4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1900</b>
9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Empl.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles M. Stotler</b>		14. MOTHER'S MAIDEN NAME <b>Ida Cromer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>347-10-9006</b>	
17. INFORMANT <b>Mrs Anna Mary Stotler</b>		Address <b>6 Main St. Keedysville, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1962</b> to <b>9-11 1966</b> and that death occurred at <b>7:30 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>9-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.E. Byrkit</b>		22d. ADDRESS <b>Williamsport Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 14, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Andrew R. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

4861

1954



VR A15 (4)  
20M 1/65

DIVISION 6  
13376

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1034 HAMILTON BLVD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MADELINE</b>		First <b>REYNOLDS</b>		Middle <b>STOUFFER</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>	
13. FATHER'S NAME <b>ELMER C. STOUFFER</b>		14. MOTHER'S MAIDEN NAME <b>EURAH F. REYNOLDS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-7288A</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 1966</b> to <b>Sept. 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 9, 1966</b> , and that death occurred at <b>7:45M</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Edward W. Ditto, Jr.</b>		22b. DATE SIGNED <b>9/12/1966</b>		22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO, JR. M.D.</b>	
22d. ADDRESS <b>215 W. WASH. ST. HAGERSTOWN, MD.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/13/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	
23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>		23e. REC'D BY REGISTRAR <b>SEP 15 1966</b>		23f. REGISTRAR'S SIGNATURE <b>Charles M. Rouzer</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		ADDRESS <b>HAGERSTOWN, MARYLAND</b>		24b. REGISTRAR'S SIGNATURE <b>Charles M. Rouzer</b>	

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## CERTIFICATE OF DEATH

13371

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN lb <u>56 yrs.</u>		d. STREET ADDRESS <u>1049 Crestwood Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1049 Crestwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Elizabeth</u> Last <u>Stover</u>		4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1878</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>66</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>State Line, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Sellers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Rummel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-9843D</u>	
17. INFORMANT <u>Mrs. Elsie Kisel</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart Disease</u> DUE TO (b) <u>Convulsed Seizures</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 21/66</u> , 19 <u>66</u> , to <u>9/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 21/66</u> , 19 <u>66</u> , and that death occurred at <u>7:25 P.M.</u> , from causes and on the date stated above.		22a. SIGNATURE <u>DE Martin</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, M.D.</u>		22b. DATE SIGNED <u>9/15/66</u>	
22d. ADDRESS <u>418 N. Potomac St., Hagerstown, Md.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>	
ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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• *Practical* • *Simple* • *Effective*

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13372

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> c. LENGTH OF STAY IN 1b <u>29yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>134 Clarkson Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>134 Clarkson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clayton</u> First <u>Lewis</u> Middle <u>Valentine</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>9</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1910</u> 9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	11. BIRTHPLACE (State or foreign country) <u>Maryville, Tenn</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles W. Valentine</u>	
14. MOTHER'S MAIDEN NAME <u>Beulah Warnner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War 2</u>	
16. SOCIAL SECURITY NO. <u>World War 2</u>		17. INFORMANT <u>Melvin Valentine Maryville, Tenn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Embolism, Massive</u> DUE TO (b) <u>Probable Thrombosis Right Saphenous Vein</u> DUE TO (c) <u>466X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		22. DATE SIGNED <u>9-10-66</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-13-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Knoxville, Tenn.</u>
24. FUNERAL DIRECTOR <u>John R. Watson of Hagerstown Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. CDUNITY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Berkeley</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro(Rural)</b>			c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney-Keeding Memorial Home</b>					d. STREET ADDRESS <b>814 No. Queen St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Edith</b>		Middle <b>M.</b>		Last <b>Vermilyea</b>		4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1892</b>		9. AGE (In years last birthday) <b>74</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTH PLACE (County & State, or foreign country) <b>Berkeley County, W.Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John W. Myers</b>					14. MOTHER'S MAIDEN NAME <b>Martha Brent</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-05-9665</b>		17. INFORMANT Address <b>Mrs. Charles B. Riker- Martinsburg, W. Va.,</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac vasculature</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 30, 1966</b> to <b>Sept 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 19, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>G. W. Libby</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>G. W. Libby</b>					22d. ADDRESS <b>Boonsboro, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-17-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hedgesville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hedgesville, Berkeley, W. Va.</b>			
24. FUNERAL DIRECTOR <b>A. K. Brown</b> <b>Brown Funeral Home</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wagnerboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>RD #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Thomas</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>October 2, 1890</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Father</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Berkley Co. West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. Hunter Walker</u>				14. MOTHER'S MAIDEN NAME <u>Effie V. Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-16-3678</u>		17. INFORMANT <u>Mrs. Hester S. Walker, RD #3, Wagnerboro, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute appendicitis--appendectomy 8-25-66. Operation 8-31-66.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	2Dd. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19 <u>  </u> , to <u>9-12-66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>9-12-66</u> , 19 <u>  </u> , and that death occurred at <u>10:30</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Brewer</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Brewer, M.D.</u>				22d. ADDRESS <u>Greencastle, Pennsylvania</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-15-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Washington Co. Md.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Greencastle, Pa.</u>				25a. REC'D BY REGISTRAR <u>SEP 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933

CENTRAL CAVE OF DEATH

1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Boonsboro</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahreny-Keedy Memorial Home</b>		d. STREET ADDRESS <b>120 E. Irvin Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EMMA</b> Last <b>WATKINS</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>27,</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 25, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. store</b>	9. AGE (In years last birthday) yrs. <b>93</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Huyetts Crossroad, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John S. Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Ann Middlekauff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Charles Watkins, Hagerstown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular</b> DUE TO (b) <b>Disease</b> DUE TO (c) <b>54</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1966</b> , to <b>Sept 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 27, 1966</b> , and that death occurred at <b>9 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G W Hevan</b>		22b. DATE SIGNED <b>Sept. 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>G W Hevan</b>		22d. ADDRESS <b>Boonsboro, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9-29-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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*David J. Reardon*

11. *Investigations of the*

John C. Winters

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London, England, U.K.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 644 JEFFERSON BLVD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last RAYMOND EDWARD WETZEL, III			4. DATE OF DEATH Month Day Year SEPT. 7 19 66						
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2, 1966		9. AGE (In years last birthday) yrs. 5	IF UNDER 1 YEAR Months 5 Days 5	IF UNDER 24 HRS. Hours 5 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME RAYMOND WETZEL, JR.				14. MOTHER'S MAIDEN NAME SHIRLEY BOSCH					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RAYMOND E. WETZEL, JR. 644 JEFFERSON BLVD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Purulent Meningitis (organism not yet identified) + Diffuse Pulmonary Hemorrhage - Spina bifida + Myelomeningocele</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7511 DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 18 hr 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9-2, 1966, to 9-7, 1966, that (I) (we) last saw the deceased alive on 9-7, 1966, and that death occurred at 8:45 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Edward W. Ditto III				ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/7/1966	
22c. PHYSICIAN'S NAME (Type) EDWARD W. DITTO III M.D.				22d. ADDRESS 217 W. WASH. ST. HAGERSTOWN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 8, 1966		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND			
24. FUNERAL DIRECTOR CHARLES M. ROUZER				ADDRESS HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR SEP 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

6-219 PP7

DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

13383

13377

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>124 W. Howard St.</b>		d. STREET ADDRESS <b>124 W. Howard St.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN LUTHER WIEBEL, SR.</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ribbon mfg.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>Augustus Wiebel</b>		14. MOTHER'S MAIDEN NAME <b>Maryetta Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Edward Wiebel, Sr.</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1966</b> to <b>Sept 3, 1966</b> that (I) (we) last saw the deceased alive on <b>Sept 3, 1966</b> , and that death occurred at <b>8 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Sidney Novenstein</b>		22b. DATE SIGNED <b>9-3-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		22d. ADDRESS <b>FUNKSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9/6/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933

STATE OF TEXAS

1933

General Accounting  
Department of the State

Revenue

Amount of money received from the sale of  
land in the State of Texas  
for the year ending December 31, 1933  
\$ 1,000,000.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13384 CERTIFICATE OF DEATH 13378									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #1 21-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>Cedar Grove</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Elias</u> Last <u>Young</u>					4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13 1886</u>		9. AGE (in years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>4</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Jerry Young Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>219 01 7393</u>		17. INFORMANT <u>Mrs. Sophia Young</u>		Address <u>Williamsport Md. RFD #1</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>2044</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>leukemia, chronic and nephrosclerosis</u> years <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and dehydration</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>61</u> to <u>Sept.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept. 18 1966</u> and that death occurred at <u>A</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/19/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>					22d. ADDRESS <u>580 Northern Avenue Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport, Md.</u>			
24. FUNERAL DIRECTOR <u>Mr. Albert L. Leaf Williamsport Md.</u>					25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

5661

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>10 hrs.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>120 S. Conococheague St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Theodore</b> Last <b>Zimmerman</b>					4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22 1894</b>		9. AGE (In years last birthday) <b>71</b> yrs. <b>9</b> Months <b>26</b> Days <b></b> Hours <b></b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown Water Plant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Cletus Zimmerman</b>					14. MOTHER'S MAIDEN NAME <b>Mary Jane Trumpower</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220 09 9221A</b>		17. INFORMANT <b>120 S. Conococheague St.</b> <b>Mrs. Harry Rupp Williamsport, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric material</b> <b>5711</b> DUE TO <b>Gastrointestinal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Acute gastroenteritis</b> (b) <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema; Bronchitis; Arteriosclerosis C.V.II.</b>									INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b> <b>7-10 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>			
21. I certify that (I) (this hospital) attended the deceased from <b>16 Jan. 1958</b> to <b>late</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>17 Sep 1966</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Richard T. Binford</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b></b>		
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>					22d. ADDRESS <b>135 POTOMAC AVENUE HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Sept. 20-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Williamsport Md.</b>			
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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CERTIFICATE OF DEATH

1. Name of deceased: *James Earl Ray*  
2. Date of death: *May 14, 1968*  
3. Place of death: *San Francisco, California*  
4. Cause of death: *Self-inflicted gunshot wound*  
5. Manner of death: *Voluntary*  
6. Age at death: *35 years*  
7. Sex: *Male*  
8. Race: *White*  
9. Date of birth: *January 19, 1928*  
10. Place of birth: *London, England*  
11. Signature of physician: *[Signature]*  
12. Signature of medical examiner: *[Signature]*  
13. Signature of coroner: *[Signature]*  
14. Signature of registrar: *[Signature]*

*[Faint, illegible text, likely bleed-through from the reverse side of the document]*

15. Date of filing: *May 15, 1968*  
16. File number: *44-38861-1000*  
17. Agent in charge: *[Signature]*  
18. Special Agent in Charge: *[Signature]*  
19. District Attorney: *[Signature]*  
20. County Clerk: *[Signature]*